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ABSTRACT

This report presents a guide to successful contracting of child and family social services during a new era in child welfare. The six chapters focus on: (1) "Privatization, Purchase of Service, Managed Care, and the Child Welfare Reform Agenda" (the continuing crisis, reforming the local child welfare delivery system, and the federal framework); (2) "Privatization, Purchase of Service, and Managed Care" (privatization, purchase-of-service contracting, managed care, and networks); (3) "Getting Started: Public Authorities and the First Decisions" (e.g., what the goals are, whether more privatization is needed, purchase of service versus managed care, whether service networks are to be part of the design, and prospects for staffing); (4) "From RFP to Contract: The Contracting Agency" (e.g., clarifying the delivery system to be created, testing the delivery system, drafting the request for proposal, and covering a portion of the Department's responsibilities); (5) "Shaping the Agreement" (rating the proposals, risk and risk sharing, outcome and performance contracting, and tough and supportive contracting); and (6) "Responding to RFPs: The Service Provider" (determining whether this should be done, weighing an independent proposal versus a consortium, and urgent considerations such as capital requirements, staffing, administrative capacity, technical qualifications, and financial risk). (SM)

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CONTRACTING FOR

Child Family

SERVICES

by Alfred J. Kahn and
Sheila B. Kamerman

A Mission-Sensitive Guide

Cross National Studies
Research Program

Columbia University
School of Social Work

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Preface

We here offer a guide to contracting for a new era in child welfare. Because much is unsettled and because preferences and judgments about the future loom large in decision making, our first two sections provide context and seek to encourage discussion. The four guideline sections that follow continue the discussion by further relevant reference to context and issues as appropriate.

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Alfred J. Kahn and Sheila B. Kamerman
June 1999

Introduction and Overview

We assume, in what follows, that a guidebook to successful contracting of child and family social services must have two foci. First, it is necessary to review the context in which innovative contracting takes place. This requires attention to current concerns, problems, and objectives that create the occasion for contracting. Second, if the public business is to be well done and the public interest served, the writing of requests for proposals (RFPs), the proposal reviews, the selection process, and the contract negotiations should be undertaken by participants with constant alertness to a previously defined and articulated mission: What is to be accomplished?

Currently, the objectives of the contracting public bodies and departments are often guided by a remarkable consensus about family and child service delivery reform at the local level developed over at least three-and-a-half decades. On a parallel track, a series of federal enactments over the past two decades has created an influential funding stream and a series of widely adopted policy targets. These are described in the text (Chapter 1) but may be here suggested as child safety, permanency (through family preservation and support, adoption, relative care), and child well-being. These enactments reflect a constant search for a policy system that will protect children in their own homes or in out-of-home care, speed up permanent and satisfactory resolutions of their situations, and result in positive outcomes for these children. But the societal context is complex, the problems are severe, and rapid improvement is illusive. Therefore, the federal policy guidance with its successive preoccupations and corrective initiatives translates into shifting emphases, ambivalence, and policy trade-offs. The agency responsible for state-level leadership must periodically review its mission if it is to navigate these seas and shape effective strategies. A periodic or ongoing participatory planning process is essential. To skip the step is to risk fadist solutions, nonadditive investments, and directionless administration.

The context in which state child welfare planning takes place also has other elements. First, there is the national political effort in some quarters, with many rationales, to downsize government and to achieve this, among other ways, by increased privatization. Much of the public child welfare program is already a

matter of voluntary sector delivery of publicly financed services. But a new wave of privatization has been under way in recent years, implemented through increased contracting out of publicly funded services to private service providers. Further, the downsizing effort, often associated with efforts to cut public social spending, often leads to attrition of public staffs or refusal to increase staffs despite increased workloads. The "solution" adopted is often privatization via contracting, which assumes or seeks service economies. The public contracts have moved from subsidies to purchase of service (POS), but more recently there has been considerable interest in a child welfare version of the managed care approach (see Chapter 2).

Our search for a knowledge base on which to construct guidelines for contracting has taken us to the professional literature and expert interviews, to research reports and documentation, and to case studies of recent developments in POS and managed care contracting. Where what has occurred has not built enough experience to merit full on-site study, we have reviewed plans, RFPs, and contracts. We touched base with almost all new initiatives visible during our experience-collecting period.

We discovered, in fact, that despite considerable promotion by managed care advocates, few (perhaps two) states can be said to have changed over substantially to managed care systems. However, there is much interest in the potential economic efficiencies of the business-oriented managed care technologies (some of which are found outside of managed care as well): management of system access, prospective payments, risk-sharing, service integration, outcome contracting, and performance contracting. There is also great interest among innovators in service-network creation, a reform that certainly pre-dates and is independent of managed care.

Advocates nonetheless prefer to describe much of recent innovation as "managed care." What are visible are new delivery and financing arrangements. The operational reality is a continuum from POS to managed care, with all cases located somewhere between the two but with no pure cases. On the other hand, many of the tools and strategies of managed care in fact have attracted state and local leaders as serving a potentially well-managed delivery system. They increasingly enter into consideration in planning, RFP writing, and contracting. This,

plus the experiences of and consensus about local child welfare reforms, management expertise, and the policy commitments that come with federal funding streams, offers a basis for our guidelines. The history is too short and the research base too limited to claim absolute validation for what we offer. Perhaps "face validity" is a better term.

This context underlies the guidelines of Chapters 3, 4, 5, and 6. We do not outline a simple proscriptive guide to action. Rather, while we outline steps, procedures, and choices for contractors and contractees, we constantly revert to mission and context. Departments, agencies, leaders, and managers have choices to make at each step of the way, and we seek to stimulate the contemplation, planning, and innovation with which they respond.

One chapter (3) focuses on parameter-setting decisions for governor, legislature, department leadership, and the social welfare professional community. Two chapters (4, 5) deal with the responsibility of the body or bodies that design and issue RFPs and eventually choose among applicants and negotiate contracts. A fourth chapter (6) focuses on the tasks facing the agency that responds to the RFP. Because the experience to date with for-profit managed care organizations is very limited in child welfare (as contrasted with health and behavioral health), we deal only briefly with the for-profit entity responding to an RFP.

Child welfare innovators are in a learning period. Guidebook users are urged to treat their choices as opportunities for creativity and as experiments, to monitor performance and child–family impacts, and then to use their experience to help move thinking and action to new levels of effectiveness. Several major issues are mentioned in the final section.

1

Privatization, Purchase of Service, Managed Care, and the Child Welfare Reform Agenda

For the past two decades, efforts have been made at the federal level to reform child welfare through an evolving system of financial support associated with a series of policy prescriptions, whose successive thrusts reflected developing conceptions of where the problems lie and what policies might improve things. Parallel to these federal efforts, as expressed in a sequence of major statutes, child welfare experts in a number of academic and research settings and child welfare officials and executives in a number of jurisdictions have invented, tested, evaluated, and advocated with reference to major reforms in local child welfare service delivery. The latter have both influenced and been guided and constrained by the federal reforms. They call for major philosophic, governance, and professional practice changes as essential to expanding and improving what they see as a poorly performing system.

In the most recent decade, particularly at the state and county level, there also has been focus on increased privatization, whether via the extensive and historically important private nonprofit sector or the for-profit sector, conceived as a contribution to enhanced efficiency and increased economy in the very expensive child welfare system. This has generated discussions and some exploration as to whether such privatization is best implemented through traditional purchase-of-service (POS) contracting or through the newer "managed care" approaches, which have migrated to child welfare because of their association with the health and behavioral health fields, where there is already large-scale managed care, much of it in large, merged, for-profit organizations. In the context of this development, questions arise as to the place of another recent delivery trend, network development, which involves contracting with local lead agencies that in turn subcontract to create comprehensive service networks.

We here offer a guidebook for the use of contractors or providers who want to find their way in this environment.

Our major conclusion after an exploration of recent developments is that those who offer contracts and those who agree to provide contracted services need to position themselves initially by their definition of mission. We view this as the determining framework. Whatever the contract form, it is mission-oriented contracting that can guide those who would spend public money to serve families and children in accord with public policy. It is mission-oriented contracting that will alert providers to the need to ensure conditions consistent with best professional practices, as they understand them. And it is mission-oriented contracting, therefore, that will best protect the well-being of children and families who come under the protection and care of the child welfare system.

Mission-oriented contracting best protects the well-being of children and families who come under the protection and care of the child welfare system.

We do not consider mission orientation to be the alternative to the efficiency–effectiveness emphasis, as some writers have suggested. Both are essential. One should be efficient and effective if one would achieve important objectives.

1. The Continuing Crisis

For several decades, much of the child welfare writing and discussion and many of the relevant congressional hearings have featured the word "crisis." Whatever their specific concerns, many public officials, citizen leaders, professionals, researchers, and advocates have proclaimed that something is very wrong, hence, the federal legislation and the efforts at local delivery reform.

It may therefore be useful, before examining reform specifics, to list the major concerns. Just what problems are people trying to face? It will occasion no surprise that there are different definitions of the problem.

What, then, are some of the expressed concerns?

- Since the mid-1970s at least, child abuse, neglect, uncontrollable behavior, deprivation, and lack of acceptable family or family-substitute support have increased (or at least increased in visibility). Also the volume of out-of-home substitute care, increasingly involving infants, has expanded. Prevention efforts are either lacking or not effective.

- Assurances of child safety are inadequate even after children in danger are identified and removed from their own homes or abusive foster care.
- There is excessive reliance on costly out-of-home solutions in efforts to help children in trouble.
- Foster care usually does not lead to reunification with one's family unless it is relatively brief.
- Too many children remain in foster care until adolescence, when they "age out," and they are not well prepared for independent living.
- The delivery system is so overwhelmed with investigating, assessing, and disposing of millions of urgent reports of abuse and neglect that it lacks resources and capacity to help families with many less extreme yet serious problems of individual adaptation, child rearing, dependency, and deprivation. As a result, these problems often become exacerbated. Nor is there much, if any, energy for "prevention."
- Systems of subsidy or payment by public departments to private agencies create perverse service incentives: to keep foster home or institution beds filled, to continue service to "fee-for-service" cases even when the family and child need a different service or could be discharged.
- The service delivery system in many places is fragmented by specialization, function, client group, and many other variables and is often lacking in capacity for program coordination or case–services integration.
- Federal funding patterns (until recent waivers) reinforce the fragmentation and complicate state and local delivery systems.
- Little accountability exists by those who take on the care of children unless or until the most extreme outcomes reach the media and public consciousness.
- The system, despite all its unsatisfactory features, is expensive and a burden for the states, localities, and voluntary agencies that, together with the federal government, finance it.

- In many parts (perhaps most) of the country, funding (salary) levels, job pressures, and political–organizational environments make it difficult to attract and retain well-trained social workers for child welfare work.

- The court system, in many localities, does not coordinate its responsibilities for child protection with those of public child welfare authorities, creating operational and resource problems where there should be effective teamwork. The child welfare system ignores the need to engage with the courts with which it shares responsibilities.

- Efforts are made to solve problems of inadequate resources, services, or performance through class-action litigation in the states by Legal Aid and similar legal advocacy groups, which leads to decisions or negotiated consent decrees in surprisingly larger numbers of states and which (whatever their substantive merits) are often beyond state capacity to reform under existing child welfare funding or administration arrangements. Or, the child welfare administration is severely controlled or constrained. Therefore, more sensible engines of reform and protection of rights are needed.

- State legislatures or governors have lost confidence in public child welfare departments' capacity to reform or have adopted "privatization" goals as they join national campaigns to downsize federal government generally and focus on child welfare.

There is also a pro-active list. Some reform impulses reflect the intent to

- Develop ways to implement prevention programs, sometimes meaning primary prevention that decreases the likelihood of child and family problems and pathology.

- Ensure early intervention to head off negative developments in populations at risk.

- Design comprehensive national or state initiatives and partnerships that ensure both preventive policy and programs and effective responses to a range of problems.

2. Reforming the Local Child Welfare Delivery System: Some Guides to the Mission

If our eye is to be on the mission, we must begin with the evolved consensus with regard to the child welfare reform agenda. The agency needs to relate to this consensus and decide how it wishes to position itself and to consider what it can do. We begin with the concept of local service delivery.

The reader of this specialized guidebook will supply and even elaborate needed caveats and contexts. Our discussion of improved child welfare does not attempt here to outline a full program for U.S. child and family policy. Long-term, families and the child welfare agencies that would help them must depend on the more extensive but still inadequate social infrastructure of income policy, employment policy, health policy, housing, child care, community recreation, education, and much more. Here the relevant issue is whether the local community or neighborhood offers adequate resources and whether the family to be helped has access to them or is assisted with access as needed by the social services system. Otherwise, child welfare interventions are likely to be inadequate.

This does not mean a definition of child welfare that is limited to "protective cases," alleged abuse and neglect, and does not offer help for other problems or earlier problems. In a national study a decade ago,[1] we found that child protection was "driving" and overwhelming child welfare to a degree that less severe, milder, or earlier cases or situations that expressed themselves in mental illness, acting-out behavior, or delinquency were deferred until serious enough to be routed to children's courts, mental hospitals, or other specialized systems. To delay help for lack of a crisis is to invite a crisis. Also, there are cases of family failure requiring public intervention even when there is no abuse.

How, then, is the scope of the discussion to be delineated? What, for present purposes, is "child welfare"? A survey of state activities does not provide a usable answer, because some states include along with child welfare what others assign to programs of juvenile justice, substance abuse prevention and treatment, behavioral health (psychiatric treatment and rehabilitation). States may therefore join together such programs in purchase-of-service (POS) or managed care contracting. Yet, to keep our discussion focused, well-delineated, and related to

federal policy making and funding, we shall here suggest, at least as a point of departure, the most typically used concept of the field. We are aided by a well-developed definition successfully employed in a recent pioneering and extraordinarily useful study of federal, state, and local child welfare spending:

[Child welfare is defined as including] the following specific services: preventive services for children and families at risk of abuse and neglect; family preservation and reunification services; child protective services (intake, family assessment, investigation, and case management); all in-home and out-of-home support services; all out-of-home placements; and adoption services... also... administrative costs associated with delivering such services, including staff case management and placement services, salaries, benefits, and other related expenses.[1]

Those who have examined available family and child social services programs, their successes and failures, have stressed a number of elements in their vision for reform. First, a case must be adequately "sized up"—what is going on, why, what are the forces in play that result in the symptomatic behavior—whether parental neglect, or abuse, or inadequacy? The professional would say that we need an assessment.

And the assessment cannot be too narrow. What is meant here? The elements are complex but familiar to the users of this guidebook. We refer to a family and child focus, to a holistic perspective and to locating the search for understanding and our strategies for help in a neighborhood–community context. We have learned as well that when one is dealing with racial and ethnic minorities, agency and staff need the capacity to bring relevant cultural understanding to bear in the assessment and subsequent helping measures. This requires both an agency philosophy and the availability of staff qualified by temperament, training, and perhaps in linguistic skills and membership in the relevant groups to function effectively. The latter requirements are often summed up as "culturally sensitive programming and culturally competent staff," phrases not always subject to easy consensus or implementation.

These qualities form the platform for what are often called "child-centered and family-focused" services, which are comprehensive and holistic. The reformers speak of a "seamless web of services" where now, almost everywhere, there is extra-

ordinary specialization and fragmentation. Researchers have documented in great detail the degree to which parts of individual cases and segments of family cases reside in different and poorly communicating agencies, departments, and units or in different staff people within one service agency. Assessments are incomplete or inadequate and services not mutually reinforcing—if not mutually contradictory. Major gaps occur in societal strategy and individual interventions. These failings have generated a series of remedies—or, more often, prescriptions for remedies that sometimes are endorsed but not implemented, implemented in part but not successfully, or implemented in experiments and demonstrations that are time limited or not brought to scale. The remedies have appeared under such names as "case integration" or "case management," "program coordination," or "program and service integration." None is ignored by those who emphasize "continuity of care" and "coordinated and integrated services," but current reforms would put all the major elements into one picture, because less would appear to be insufficient.

Our discussion of improved child welfare does not attempt to outline a full program for U.S. child and family policy.

There has long been discussion of the accountability to community and clients of an agency that accepts public funds to accomplish community tasks. Recently this principle has been further elaborated: Agencies commit themselves to achieving specified community outcomes and, as the state of the art improves, the degree of specificity and even quantification of outcomes increases. Under "managed care" they may share financial risks with contracting authorities, gaining or losing, as they attain or fail to achieve outcomes sought.

We have implied but not elaborated one aspect of the reform agenda that has been discussed for some time but is now appearing with new specificity and vigor: It is argued that services are more likely to have the characteristics sought if they are community based (decentralized, where feasible, to the local neighborhood), have local involvement in or control of their governance and, in the case of foster care and some other services, operate under a system that the Annie E. Casey Foundation has named "Family to Family" (see below). Community-based services are now often seen as the fulcrum for effective assessment, for a focus on family and child that is holistic, in context, and culturally sensitive and supportive of

similarly oriented interventions. The neighborhood base (variously defined and admittedly sometimes difficult to specify)[8] is the natural locus of case management and services integration designed for effectiveness and user convenience.

Particularly in designing substitute care, but also for family support, family socialization services, child care and recreation programs and many activities currently based in other systems (job counseling, support in the transition from "welfare to work," housing referrals), the community base is increasingly promoted as central to effective service delivery reform.

From among the distinguished current advocates of this approach we quote Frank Farrow, reporting for the Executive Session on Child Protection at Harvard University's John F. Kennedy School of Government:

Effective neighborhood-based supports and services requires the use of family networks, friends and other informal supports, the commitment of a wider array of formal services, and a willingness to change the way public services are now organized.

Drawing on family networks and other informal resources is as important as expanding formal services. These networks, often including friends, relatives, and neighbors, are closer to and more trusted by struggling families than are most traditional formal services. Equally important is the need to reorganize service delivery. Moving services into neighborhoods and creating teams of public agencies and community resources makes services more accessible. Having a community partnership for child protection that focuses on each specific community builds bonds of accountability, trust, and knowledge between service providers and community residents.[9]

The report holds that such partnerships cannot begin without parental involvement. It predicts that successful community partnerships may evolve into systems of community governance that assume responsibility for keeping children safe.[10]

An important literature on community-based services will interest contractors and providers. For illustration, we cite a vision statement from New York's Administration for Children's Services (ACS), which adopted this outlook as it took "bids" for child welfare services late in 1998 and early in 1999, the first step (covering the Bronx) of a contemplated city-wide evolution and reorganization. (The reference to "Family to Family" is to an Annie E. Casey Foundation demonstration funded over a four-year period in selected states.)[11]

A neighborhood based, community oriented service system will, when appropriate, allow children who need foster care to be placed in homes within their communities so that they will not have to change schools, leave their friends, or lose contact with their families. Support services and extended networks of care would similarly be provided in the community for the child, the birth parent(s) or caretaker(s), and the foster parent(s). In this way, children and their families will have maximum access to a range of services that closely reflect and respond to their particular needs, and the important bonds a child has with his/her environment will be kept in place during this potentially trying and difficult time. Such a system will reduce the trauma of separation while increasing the possibility, timeliness, and quality of permanency for the child, with a primary focus on child safety. A community oriented service system will further ensure that culturally and linguistically competent service system will further ensure that culturally and linguistically competent services are provided throughout child welfare.

To support ACS reform goals and to create an even more effective and integrated neighborhood-based service model, ACS believes that a Family to Family service philosophy and approach needs to inform the design and delivery of all child welfare services, with particular focus on foster boarding home care. Through a Family to Family approach, birth parents or caretakers and foster parents are viewed as the most essential individuals to a child's life. Whenever appropriate, foster parents become actively involved with the children's birth parent(s) or caretaker(s) before, during, and after placement. A Family to Family approach seeks to create a "community of care" for the child which is comprised of those individuals most central to and concerned about the child's well-being—the birth parent(s) or caretaker(s), foster parent(s), and caseworkers.

But how can such a design accommodate the larger service or treatment facility, a specialized program for only a few children from any given neighborhood? Here ACS offers what appears as a realistic formula consistent with its overall philosophy:

Like other child welfare services, congregate care programs and facilities should be neighborhood-based whenever possible and reflective of and responsive to each child's specific culture, background, and needs. When facilities are not or cannot be located in the child's home community, relationships need to be established with that community to ensure that the important bonds a child has with family, friends, and

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local institutions are kept in place. Additionally, relationships need to be established with the community the child will be residing in after discharge (if known), in order to ensure a successful and healthy transition to life outside of the foster care system.

Interestingly, this vision is offered by ACS as part of a mission statement.

This, then, is a brief summary of a gradually accumulated reform agenda, created out of the research, innovative thinking, pilot work, and advocacy of organizations such as the Center for the Study of Social Policy (Washington, DC), Chapin Hall Center for Children at the University of Chicago, the Child and Family Policy Center (Des Moines, IA), committees and special projects of the American Public Human Services (Public Welfare) Association (Washington, DC), the Child Welfare League of America (Washington, DC), the Family Resources Coalition (Chicago), and numerous smaller centers and local initiatives. They have constituted an unorganized movement for societal learning with considerable interaction among some and a literature of both research and general publications. Is it an agenda fully validated with rigorous research and "clinical" trials, demonstrating effectiveness with regard to child safety, "permanence" (a concept discussed below), efficiency, or child and parental development—among the major criteria to be considered? Here one can refer only to small studies, qualitative evidence, testimony, and public official and legislator approval, sometimes client statements of satisfaction. But this is what we have as we move forward. Call it "face validity" or "our best bet."

The platform for "child-centered and family-focused" services are comprehensive and holistic.

It nonetheless is more than reasonable to hope that an agency that would contract for services or the provider who bids for contracts or applies for grants will want to place themselves within this picture—so as both to articulate clearly what is being sought and offered and watched for—and to provide a basis for defining one's bottom line: "Can the bidder deliver in these terms?" "Can I deliver in these terms?" "When all the contracts are signed and sealed, will there be progress on the child welfare reform agenda?"

Contractor and contractee, then, will want to be deliberate about mission-orientation by reference to the agenda for local delivery reform.[9] They will also

want to touch base with the federal policy framework and related funding opportunities that grow out of that framework and to which we now turn. Will the context be consistent with national goals and objectives as adapted within one's state?

3. The Federal Framework: The Other Component of Mission

Here, too, a brief summary may be in order. For most of the readers of this guidebook, this will be familiar material. Yet it needs to be introduced as a reminder for those who are determined that financial and delivery system reforms advance a well-articulated mission.

The evolution of the federal child welfare role has extended over almost 90 years, but the enactments since 1980 are most relevant for our purposes. However, a brief summary of the earlier history will add somewhat to the clarification.

American society has always offered children some protection, from the pre–Revolutionary War colonial laws to the late-19th-century voluntary child protection agencies (New York Society for the Prevention of Cruelty to Children, 1875). The U.S. Children's Bureau sounded the alarm about child labor and child mistreatment from the time of its establishment in 1912; just before and after World War I most states established juvenile courts and passed laws giving such courts jurisdiction over child maltreatment (as well as delinquency and uncontrolled behavior). The 1930 White House Conference on Children featured the "dependent child." Thus, federal and state interests were expressed, and vehicles for action began to develop.

The first federal child welfare financial commitment came with the Social Security Act of 1935.[11] What we now think of as Title IV-B evolved out of a subsection of Title V in the original act: Each state would receive a grant each fiscal year to enable the states to create state-wide child welfare services "for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent...."[12] The committee proposing the act had noted the inadequacy of coverage in the vast majority of states. (Abuse had not become a visible national issue.)

A larger financial commitment was made in 1956. Then, for the first time, services in public assistance programs were made eligible for specific federal reimbursement (50 percent), whereas service previously had to be justified as

"administration." Because substantial overlap was recognized, a major theme was the need to coordinate child welfare services with public assistance administration (Aid to Dependent Children, or ADC) as public assistance social services improved. The intended coordination did not occur then or in subsequent decades to the satisfaction of federal policy makers or child welfare critics. However, in 1961, when several southern states attempted to remove unwed, mostly black, single-mother families from the ADC rolls in a mass categorical disentitlement on the basis of "unsuitable homes," the Secretary of the then Department of Health, Education, and Welfare ruled after hearings that such policies could not be followed unless the involved state (then Louisiana) moved in court to find the parents who provided unsuitable homes to be neglectful, thus providing the children with alternative care. Foster care was and is far more expensive for a state than ADC, and the new policy stopped the mass case closings. However, to help states that decided to offer foster care to children in court-labeled unsuitable homes, federal matching was established for foster care payments for ADC children placed in foster care as a result of court action. This provision was soon part of the requirements for state plans. In 1962, the amendments that converted ADC to AFDC (Aid to Families with Dependent Children) also required extension of child welfare services to all state jurisdictions and increased federal reimbursement (to 75 percent) for social services to help families and end the dependency requiring cash assistance.

Although there was good cause to be concerned about children "lost" in the foster care system from the 1950s, as the research-drawn picture from Henry Mass and Richard Engler[13] was elaborated, the jolt that created much greater federal involvement and financial participation came in 1962 when Dr. Henry Kempe, and then others, showed medically through their research that what had often been mislabeled as child accidents (falls, etc.) were in fact instances of child battering, often by parents or other caretakers.[14] Whereas child welfare had long considered itself to be concerned with child neglect, dependency, and potential delinquency, child abuse now came to the fore (so much so that the imagery of physical and sexual abuse dominates policies today to a point where neglect, while listed as the more prevalent problem, is often "neglected").

From the early 1960s, federal actions and congressional attention have followed two tracks, which are obviously related to one overall phenomenon but which

reflect different preoccupations: the child abuse track and the foster care track. With reference to the first, the Kempe-generated interest in child protection led to the issuance by the U.S. Children's Bureau of a model reporting law and (by 1968) mandatory reporting laws in all states. Then, in 1974 the Congress passed the Child Abuse Prevention and Treatment Act, which referred to neglect almost as an also-ran.[1] In retrospect, this legislation passed when the belief was that if abuse was reported it could be stopped—and that the desirable responses were known. States would be funded if they established comprehensive reporting and investigatory systems: physicians and other professionals who have frequent contact with children are required by these state laws to report abuse and neglect that comes to their attention—but all citizens, especially neighbors, may report. Funds were made available for large-scale advertising campaigns urging prevention of abuse (but not specifying just how), and encouraging reporting. Demonstration funds were made available to individual agencies, which proposed what were regarded as innovative reporting, prevention, and intervention projects (initially treatment largely of victims, but in later years of "perpetrators," too). A veritable child abuse industry grew on this basis, but the demonstration funds were limited, the learnings generally not cumulative, and the coverage spotty. This legislation has been reauthorized regularly, and both federal administration and grant emphases have evolved in ways not immediately relevant. Several national voluntary sector associations, with considerable federal funding, are now offering program leadership.

■

The evolution of the federal child welfare role has extended over almost 90 years.

The Congress, however, since the late 1970s, has begun to give more systematic, substantive attention to what happens to the children after they are reported and is using federal funds to attract states to its approach. These funds are so important that, in effect, there is now a framework of policy, which states ignore only at their financial peril. Child abuse response is seen in relation to all child welfare services. It is the evolution of federal policy for dealing with almost-placed or placed children and their families that we here review as especially relevant to this guidebook. We refer specifically to four pieces of subsequent federal child welfare legislation: 1980, 1993, 1994, and 1997. The legislation

reflects a still unresolved effort: to balance child protection and child safety as against family preservation or reunification: to ensure expert decision making and planning for children, while favoring relative and kin solutions and often applying very different (or few) standards to them: and to give major priority to the new "required work" policies in public assistance (Temporary Assistance to Needy Families, or TANF), while also giving major priority to creating or recruiting secure home settings for children—and without capacity to resolve the potential incompatibility of these motives.

A few words are said here about each of the enactments and about the "welfare reform" of the summer of 1996. The watershed federal enactment was the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272). It followed a series of 1970 studies, which repeated research findings going back to the mid-1950s, showing that if children were not united with their families quickly or otherwise ensured secure life plans, they would spend long years forgotten in foster care at considerable public cost. And the foster care rolls kept growing. The laws combined a series of carrots and sticks to change the picture. A new Title IV-E was added to the Social Security Act, combining the AFDC foster care program with a new adoption assistance program for "special-needs" children as an entitlement budgetary authorization. To qualify for Title IV-E matching funds (at its AFDC matching rate), each state was required to create a foster care information database: to establish pre-placement prevention services, including provision for a judicial finding that reasonable efforts had been made to prevent the child's removal from home; to ensure careful development of a case plan for each child in foster care, such plan to achieve placement in the least restrictive (most family-like) appropriate setting and in close proximity to the parental home; to have a reunification service program designed to help children return to their own homes when appropriate or—if that is not possible—to achieve another placement such as adoption or legal guardianship; to establish a monitoring case review system involving an administrative review every six months of the central issues in the case—the continuing need for foster care, plans for return home or adoption, or another permanent plan. Within 18 months of the original placement there was to be a dispositional hearing in the appropriate court or by a court-appointed administrative agency. The phrase "permanency planning"

entered the child welfare vocabulary and became a central tenet: Children had a right to a stable life-plan and should not spend long indeterminate years in temporary foster care.[16] Major federal auditing of state programs had become a fact of life for the states (reviews provided by section 427 of Title IV-B). Another new fact of life is the statutory basis offered for constant challenges to the adequacy of state or county efforts by Legal Aid or other legal advocacy groups and the resultant court "class" decisions and consent degrees that are ever present for state and county child welfare officials and governmental bodies. As informed readers know, these consent decrees and difficulties in abiding by them have entered in a major way into decisions to privatize child welfare services and helped shape the substance of the contracts.

The activity of the past two decades in child welfare may be seen as reflecting the policy pressures from the constant federal efforts to both implement its child protection objectives and to bring life to the concepts of P.L. 96-272. It is beyond our present scope to detail the efforts to clarify concepts and best practice at state and federal levels, the research and training undertakings, and the frustrating attempts to develop databases and obtain a national picture of developments. In our own work we were impressed with the problems created for states by the double-bind:[17] public pressures created by the child abuse legislation and grants prompted public authorities to remove children from their homes if they were in danger. Because an error could mean a fatality and major difficulties for the authorities involved, there was reason to remove and place. On the other hand, all the ideology and machinery of P.L. 96-272 spoke for family preservation. There was no satisfactory resolution.[18] The story was complicated further by the mandates on Title IV-E Child Welfare funds, redefined by the 1980 legislation, as encompassing a social prevention mission but also as supporting all of the new policies for IV-E. Inevitably the protection, care, and reunification responsibilities were to overwhelm basic, primary prevention, because emergencies are visible and prevention involves slow institutional adaptations and changes.

Because national foster care databases had problems, one could say at most only that briefly there may have been a decline in foster care totals after the 1980 legislation and that the declines may have been sustained to 1982 or even to 1987, only to be followed by a continuing and persistent explosion in placement

numbers and rates, which continues. Of special concern is a major rise in infant admissions into care, believed to be associated with increased substance abuse by mothers from the mid-1980s—and the research finding that younger children remain in care longer.

Alarmed at reports of what happened to young people when they aged out of foster care, the Congress also established in 1985, effective 1987, an Independent Living entitlement appropriation program providing funds to the states to help youth in the transition between ages 16—when Title IV-E foster care payments cease—and 18. Later extensions increased the funding, extended the age at state option to 21, and elaborated program possibilities.

Because the foster care flow continued and child welfare IV-B funds went largely into sustaining child welfare care services, the next major federal action was an attempt to strengthen prevention, as variously defined as primary prevention or prevention of placement—or some point in between. In 1993 a new subpart 2 to Title IV-B created the Family Preservation and Family Support Program. A block grant (75 percent federal match with a ceiling) gave the states some new money (currently over $200 million annually) when Title IV-B was virtually frozen. It was passed in an environment of great enthusiasm and optimism based on early evaluations of new intensive family preservation programs, especially a pace-setting program known as Homebuilders. These were flexible, short-term, comprehensive and intensive, "whole-family" interventions at the point when placement was imminent, and they were judged by success in avoiding placement. A variety of family prevention models evolved around the country, some more intensive than others, and some not necessarily waiting to come into play until a placement decision was made. The family support option in the legislation, expected to be a secondary component, was also variously interpreted. To some it called for primary developmental and socialization services and parent education for vulnerable populations who had not yet developed problems. Others—the majority, out of need to deal with visible danger—tended to steer cases in with early or modest problems, hoping to offer help that would avoid a downward course.

Federal actions have followed two tracks: the child abuse track and the foster care track.

Unexpectedly, family support programs proved to be the more popular option in the legislation.

In the meantime, as family preservation evaluations went beyond the promotion of the concept and reflected the greater diversity of programs, doubts began to appear. There were many evaluations, and results were decidedly mixed. Some skeptics asked whether failure to place, something under agency control, could be an adequate success criterion. Congress in 1993 authorized a rigorous study, and a national evaluation is under way involving a randomized trial design, a large variety of sites, and a diversity of outcome measures. A report is expected soon. In the meantime, we have found in our current explorations major variations in the ways in which states use family preservation and family support concepts and funds—and in how these activities enter into contracting.

Shortly after the enactment of these programs, the forces in the Congress, or the states, or the provider communities concerned with the slow flows to permanency successfully enacted (1994) the Multiethnic Placement Act. In the 1950s, interracial adoption had been regarded as one way to help speed the passage of African American children out of foster care. The disproportionately large numbers of such children in need of care and the inability of the African American community for a variety of economic and demographic reasons to absorb many of these children seemed to call for such a solution. The agencies that developed interracial adoption programs, and the white parents who adopted were regarded as humane pacesetters, willing to cope with stigma and prejudice. The environment changed with the "black pride" movement of the late 1960s; some black Americans did not want black children removed from "their" community. A few advocates introduced the word "genocide." The National Association of Black Social Workers (NABSW) adopted a strong policy condemnation of interracial adoption.

Although adoption numbers increased modestly with the slow growth of a black middle-class, the situation that led to interracial adoptions persists today. African American children are in long-term foster care in disproportionate numbers and remain there. Other advocates in the Congress shaped the 1994 legislation barring discrimination against potential foster or adoptive parents solely on the basis of race, color, or national origin. However, the law has its

caveats. The child's needs with regard to racial or cultural identity are not to be forgotten. Those who oppose interracial adoption have not changed their stance. It is not clear that the picture has changed since this ambivalent legislation, but a determined agency would seem to have more leeway. A late 1998 survey by the American Public Human Service Association reports compliance in law and policy, a grievance procedure with few complaints as yet, and the expectation that 1997 legislation (see below) rather than the Multi-Ethnic Placement Act may soon be shown to have increased adoptions.[20]

We thus arrive at the most recent efforts by society to get its priorities in balance in a complex field. Impatient with the protective programs that still seem to miss some horrible cases of child abuse and neglect, some resulting in child deaths; with preventive and family preservation efforts that have not stopped the explosion of foster care; and with the inability of programs in place to promote early "permanency" on a sufficient scale, the Congress in late 1997 enacted the Adoption and Safe Families Act (P.L. 105-89). In effect the act intends to speed up child adoptions while increasing child safety. Going beyond the licensing requirements of Title IV-E, states are to develop standards to ensure quality services to protect the health and safety of children in foster care. The act (contrary to 1980) enumerates cases in which efforts to prevent placement need not be made. It also tightens the timeline for a final disposition, including termination of parental rights, going from 18 to 12 months. Children are to be protected, rescued, and ensured early permanency. There is great pressure to move toward adoption if families cannot be preserved or unified, to the point where there is to be "concurrent planning," which saves time by pursing both options simultaneously. There are also significant financial incentives for states to achieve the adoption of foster care children with special needs. There are new provisions mandating state actions to terminate parental rights under a variety of circumstances. The act adds both family unification services and adoption promotion and support services to the family preservation and family support program, now called "Promoting Safe and Stable Families."

This fluctuation of the pendulum again away from family preservation and toward child protection is probably inevitable in view of oversimplified definitions of alternatives and the inability of federal legislation (or professional

expertise)—if it would be specific—to devise and enact universal case evaluation and disposition-planning formulae.

Parallel to all of these developments since the 1980s has been an increasing tendency in the courts to choose relatives over outside foster care facilities as consistent with family preservation and cultural competency. It became a major 1990s pattern, taking a variety of forms: kin awarded foster care payments as alternatives to foster homes, kin as AFDC caretakers (with the lesser grants), and kin (especially grandparents) as guardians. Kin placements are especially likely for infants and toddlers. In several large states, kin foster care became a major development (half the New York City foster care population early in the 1990s, for example). Some states subject kin foster parents to the same standards as all foster parents, but it is likely that they are the exception. Courts often prefer relative placements as appropriate and simpler, and some courts are less probing about kin than are competent child welfare agencies. The suspicions about the authenticity of some placements are not resolved: Is it a way to get parents better financial aid than TANF/AFDC, and is it a solution for some parents to TANF work requirements that they cannot meet? To return to the earlier discussion of local service delivery: Is kinship care to be regarded as a variation on "Family to Family?" Thus far we know that reunification is slower and placements last longer (subsidized permanency) in kinship foster care. And kinship care is more common in African American and Hispanic families than among non-Hispanic white families.

The picture has been complicated somewhat by the so-called "welfare reform" of August 1996 (Personal Responsibility and Work Opportunity Reconciliation Act, P.L. 104-193). Immediately relevant, the law included provisions that: enable for-profit child care institutions to participate in federal foster care program funding for the first time, mandate a national random sample study of children in the child welfare system, and require states as a component of Title IV-E plans to consider giving preference to adult relatives in determining a foster or adoptive placement for a child. But the work rules and potential sanctions against nonconforming parents receiving TANF could accelerate movement of children to kin or to foster care where the child's or the family's interests would seem to call for enhanced efforts to protect family integrity, not for punishment.

There is no reason to regard this as the end of the process. The pendulum moves back and forth between child protection and safety (and therefore permanency as adoption) on the one hand and permanency as preserving the biological family and protecting parental rights on the other. Somewhere in between is kin care, to be seen as anything from a funding stream, to an instrument of family preservation, to one of alternative permanency. A third goal in the iron triangle of child welfare reform is child well-being, and the data linking this outcome to existing interventions are almost nonexistent thus far. The delivery reform must develop within the framework offered by federal requirements and state plans. The emphasis on the community base and family to family places the movement on the side of family preservation and re-unification. The assessment machinery is charged with identifying those cases for which such policy is not suited.

Now, we turn back to public departments that issue RFPs, inviting bidders to compete as potential providers, and to the agencies that would prepare proposals. One needs to be alert to these policy currents and how one's organization regards them. What professional ethical stances, concepts of best practice, or organizational constraints are operative? How does one interpret the implied mission? What must the contract offer to keep viable one's commitment to mission?

Notes

[1] Sheila B. Kamerman and Alfred J. Kahn, *Social Services for Children, Youth, and Families in the United States* (Greenwich, CT: Annie E. Casey Foundation, 1989). Reprinted as Special Issue of *Children and Youth Services Review* (Vol. 12, Nos. 1/2, 1990). Also see Sheila B. Kamerman and Alfred J. Kahn, "If CPS is driving child welfare—Where do we go from here?" *Public Welfare*, Vol. 48, No. 1 (Winter, 1990). Reprinted in 50th Anniversary Issue, Vol. 51, No. 1 (Winter 1993).

[2] Robert Green, Shelly Waters Booth, and Karen C. Tumlin, *The Cost of Protecting Vulnerable Children: Understanding Federal, State, and Local Child Welfare Spending* (Occasional Paper No. 20, "Assessing the New Federalism," Washington, DC: Urban Institute, 1999), p. 4.

[3] For an informed and helpful history of reform strategies, including those that are local community based, see Robert Halpern, *Fragile Families—Fragile Solutions: A History of Supportive Services for Families in Poverty* (New York: Columbia University Press, 1998), especially Chapters 9, 10.

[4] Alfred J. Kahn and Sheila B. Kamerman, eds., *Children and Their Families in Big Cities: Strategies for Service Reform* (New York: Columbia University School of Social Work, 1996).

[5] Frank Farrow, *Child Protection: Building Community Partnerships* (with the Executive Session on Child Protection) (Cambridge, MA: Harvard University, 1997), p. ix.

[6] *Ibid.*, p. x.

[7] "Family to Family: Reconstructing foster care." *Focus: A Quarterly Report From the Annie E. Casey Foundation*, Vol. 2, No.1 (Winter 1992), pp. 10–12.

[8] Administration for Children's Services, The City of New York. *Request for Proposals for Child Welfare Services in the Borough of the Bronx* (June 1998), "Appendix G: Foster care standards," p. 2.

[9] For example, Charles Bruner and others. *Resource Briefs 1–7* (Des Moines, IA: Child and Family Policy Center, 1992, 1993, 1994). Joan Wynn et al., *Children, Families, and Communities: A New Approach to Social Services* (University of Chicago: Chapin Hall Center, 1994).

[10] On vocabulary: There is some inconsistency in use. We use the term "contractor" for the agency or public jurisdiction or department, which offers the contract. We use the terms "contractee," "provider," and "lead agency" for the entity that submits proposals, applies, and makes bids to become the agent of the contractor. The "lead agency," in turn, may subcontract with other providers.

[11] The Sheppard–Towner legislation funded a maternal and child health program in the states, 1921–1929.

[12] *The Social Security Act of 1935*, P.L. 271-74, Title V, Sec. 521.

[13] Henry S. Maas and Richard E. Engler, Jr., *Children in Need of Parents* (New York: Columbia University Press, 1959).

[14] C. Henry Kempe et al., "*The Battered Child Syndrome*," The Journal of the American Medical Association, 181, (July 7, 1962), pp. 17–24.

[15] A Senate subcommittee that did not have jurisdiction over the basic Child Welfare Program followed the lead of the then Senator Walter Mondale and thereby created something of a split in policy for a while. See Barbara J. Nelson, *Making an Issue of Child Abuse* (Chicago: University of Chicago Press, 1984), pp. 100–104.

[16] This orientation was probably influenced by the thinking about the "child's sense of time" in Joseph Goldstein, Anna Freud, and Albert J. Solnit, *Beyond the Best Interests of the Child* (New York: Free Press, 1973).

[17] See note 1.

[18] *Ibid.*

[19] Select Committee on Children, Youth, and Families, U.S. House of Representatives, *No Place to Call Home: Discarded Children in America* (Washington, DC: U.S. Government Printing Office, 1990). See also Committee on Ways and Means, U.S. House of Representatives, *1998 Green Book* (Washington, DC: U.S. Government Printing Office, 1998), pp. 772–812, especially table on p. 773.

[20] American Public Human Service Association, *Survey Results: State Implementation of MEPA and ASFA* (Washington, DC: *Author*, 1998).

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2. Privatization, Purchase of Service, and Managed Care

When the child welfare reform agenda rises to the level of action, states and localities decide how to move and do so in the context of a new environment. The ideology calls for privatization, and the major administrative and policy tools are associated with either traditional purchase of care contracts involving fees for service rendered or—more recently—some or all of the business tools of managed care as developed in the medical field. These, in turn, guide the specifics of contracting. Our next four chapters are best seen with reference to this context.

In a larger sense, the current dominance in the industrial world of market liberalization has affected both the government and the nonprofit institutions engaged in social welfare and social services activities in the broad sense of these terms. Market instruments (or business ideologies and practices) migrated to these areas and are now more influential in this country than at any time since the post–Civil War Gilded Age. In what follows, we summarize briefly some of these developments as reflected in child welfare. We do this with full awareness of the rapid changes currently under way. Even as we focused on developments in active states, the boundaries between purchase-of-service (POS) contracting and managed care contracting, for example, began to erode, creating new combinations, as we shall observe subsequently.

A comment about business and market thinking in social welfare programs: Social welfare has always signified access to benefits and services by other than market criteria. There is societal consensus, and its core values insist that some things are so important that they should be available despite individual or market failure. Therefore, as market and business devices are introduced to promote efficiency and effectiveness and to control social services costs, it is urgent that they protect client access. Services (and benefits) should not be closed off by the new organizational and administrative departures.

1. Privatization

Of all the social services fields, child welfare has always had a large nongovernmental, noncommercial component. Its origins were in mutual-aid and religious charities. Its substantial sectarian and nonsectarian voluntary components whether in child protection, institutional placement, and foster homes, or its socializing and developmental components such as boys' and girls' clubs and centers were compatible with predominant views of family responsibility, of religion's contributions, and of government's proper (limited) roles until well into the 20th century. Government might give grants or pay subsidies, but these programs were privately operated.

The shift from the 1930s through the 1970s was extraordinary. Some parts of the country lacked a large voluntary sector development and, in any case, the volume of need far exceeded private agency financial capabilities. The United States developed federal public social security and public social services systems in the mode of most industrialized societies, and in the course of this a large public child welfare component, including subsidies for foster care, eventually emerged. The federal public assistance programs developed associated social services and most of the states invested heavily out of their own funds in services and facilities for dependent, neglected, abused, delinquent, disabled, and handicapped children. In the midst of the process, for a variety of reasons that will not be repeated here, government also began in the 1970s to privatize further—that is, to shift more of its own social services investment to private delivery by contracting. Especially in the 1980s and 1990s the process accelerated. Statutory changes supported it. By now, of publicly funded child welfare services over half are delivered through the voluntary sector. Some two-thirds of voluntary sector child welfare funds come from government (and this may exceed 90 percent in significant numbers of places).[2]

Thus there is nothing new about private sector delivery of social services, and privatization—the reduction of the public sector role in favor of the private—is not new either. What is here relevant is the two-decade thrust, recently accelerated again, to go even further.

The broader context, which affects public opinion and political debate, is relevant. Government in the countries formerly dominated by the Soviet Union have

been selling off industries, utilities, and banks to private sector entrepreneurs under Western capitalist guidance. Some European welfare states are (to different degrees) privatizing such previously publicly owned companies as airlines, telecommunications, and railroads. Some states and cities in the United States are privatizing prisons, road maintenance, garbage collection, and vehicle inspection. And these are only selective illustrations. The methods for these privatizations range from asset sales to deregulation to franchising to elimination of public functions. Most relevant here, the vehicle is often a contract with a private provider to produce or deliver a service. This is the most common form of privatization in the United States.

Why privatization? On the level of political debate the campaign for accelerated privatization in the United States usually is described as part of the downsizing of state or federal government, said to be currently too intrusive in people's lives. Moreover, this government downsizing is, simultaneously, believed via competition and rewards to enterprise to enhance economy and efficiency, attractive motives to both taxpayers and political leaders.

The downsizing objective clearly has had some successes if the issue is the size of the public work force (but state expansion, overall, has paralleled federal contraction). However, if despite privatization actual services are not also cut or eliminated, public expenditure may rise or fall under downsizing, depending on the course of the contracting and subsidies over several years. Obviously, the results can be different for well-standardized and monitored products or services (garbage collection or water metering) from results for complex and unstandardized services in corrections or mental health or social welfare. Commitments to quality or to professional accreditation standards or to particular policies also may limit the maneuverability of a new private sector management or new contractors. Economies can be achieved if privatization permits escape from civil service and other governmental rigidities, union agreements, and prevailing salary and fringe benefit commitments. This may or may not speak well for quality, of course. And economy–efficiency can sometimes be demonstrated by new, creative, outside leadership, departing from old assumptions and practices.

The research reviews of privatization via contracting do emphasize the differences between "concrete" products and services and more complex, subtle services. Our own reading is that in each of these fields the evidence is mixed.

There is impressive evidence of results achieved in each, as there is of unsuccessful initiatives. Economy–efficiency via privatization may be real but sometimes involve a sacrifices of quality or of labor protections and standards.

The empirical explorations lead to a standoff. There are validated successes, blind alleys, and failures, but there is no decrease in enthusiasm for privatization currently in the broader political and cultural environment. Often state legislators or governors will permit service innovation or expansion and make new funds available as long as the number of public employees will not increase. Therefore, although it is possible to generate long "pro" and "con" lists, it would appear to be more useful to remain neutral with regard to the ideology and to recognize that each stage to more privatization may be regarded as a planning opportunity, another chance to ask how the child welfare reform agenda may be advanced. Further, from our "pro" privatization list (which assumes that the vehicle is contracting with the private sector), we note[1]

- Efforts toward privatization—the very process—may provide an opportunity to clarify boundaries, responsibilities, and relationships between the public and private sectors.
- Contracting permits a public agency to expand its service delivery activities without increasing its staff or confronting restrictive civil service regulations or state or county ceilings on hiring.
- Contracting provides access to expertise that public agencies may not have on staff.
- Contracting may more readily promote volunteer citizen participation in program innovation, governance, and service delivery than most formal government bureaucracies.
- Contracting can expedite a response to new service needs, bypassing slower-moving public bureaucracies.
- Contracting may promote the creativity and efficiency that result from open competition.
- Public officials can purchase specialized services through POS contracting that would be difficult to fund or develop in a public agency.

- Contracting partly shifts the political and financial risks of providing services from a government agency to the nonprofit sector.

Privatization, it should be noted, does not necessarily mean full public funding of an activity. The public contract is often written on the premise that agencies will continue to receive and use philanthropic funds. (That was the case in Kansas, among our illustrations). Or the voluntary agency may decide that it must supplement the public contract to meet its own standards (the occasional practice of a New York City agency that we explored).

States have more flexibility at this time as they privatize because of a federal policy of waivers under the Title IV-E funding stream permitting (on application and approval) major service delivery innovation and, particularly, the use for family preservation and permanency services of funds previously dedicated to foster care. At least 20 states already have approval for many types of reorganization and reform in using this funding stream.

Some observers describe privatization as load shedding, the relinquishment or abandonment by government of some of its responsibilities for financing, production, and regulation of social services as it contracts with the private sector. Load shedding would be an inappropriate policy given the situation of families and children and federal or state statutory commitments. We have seen earlier manifestations of such motives but do not observe load shedding as a major motive in current child welfare contracting. And, as suggested, it can be an opportunity to consider new things, to add greater efficiency and effectiveness to child welfare programs. These objectives do help focus both writing requests for proposals (RFPs) and provider responses.

2. Purchase-of-Service Contracting

As the government commitments grew, the financial support pattern moved away from substantial reliance on one-time or periodic grants or subsidies to more business-like contracts involving fees for service or per diem payments. Agencies and government would agree on rates for given types of services to be made available to a community (a senior center, a family "drop-in" center), to specified types of clients (treatment, adoption, care in a congregate institution), and for how

long. The government RFP or single-source contract would specify a price for each service over a specified time period and, after negotiation, where permitted, the price would be part of the contract, or the rate might be initiated by the agency on the basis of its own experience and financial analysis. The contract could commit the provider to serve all "comers," particular comers, or only those referred by specific public authorities (the diagnostic center that studies court referral cases under its public contract but also has separate financial arrangements for referrals from other sources). The agency would bill at agreed times for services rendered.

Where do these things now stand?

POS contracting has emerged as the dominant approach to delivering publicly funded child and family social services. POS contracting can take several forms, depending on the nature of the buyer–seller relationship and the nature of the services to be purchased. Thus, for example, it may involve a contract with an entire agency to deliver services to all who qualify, or it may be designed for a practitioner to provide services for a few individuals whom a public agency defines as qualified for aid. Contracting arrangements may be for a few months or for several years, but are most often for one or two years. The provider may offer services to all who come to the agency or only to those referred to it by the public agency, or may have its clientele limited in some other fashion. The contracting process may involve an RFP, in which the state tells bidders the services it wants to offer and the objectives it wants to achieve, and the bidders submit plans and cost estimates for meeting the specified requirements. Or it may involve a request for quote (RFQ), where the state has a specific model it wants to implement and specifies in advance not only the services required, but also the staffing patterns, caseload size, supervisory ratios, working hours, and so forth. The bidder suggests a price. Contracts may be terminated if the provider fails to live up to the agreement or if public funds dry up.

Two-thirds of voluntary sector child welfare funds come from government.

Several public officials reminded us how different the contract world is from the grant world and that this could present real problems to community-based organizations (CBOs). To handle contracting, an organization needs a legal staff

or resource and a sophisticated billing, bookkeeping, and budgeting capability. It is not clear that most CBOs are able to cope with the administrative and management requirements of the contracting agencies, despite anecdotal evidence of some successes.

Lipsky and Smith point out that there are different types of social services agencies, and that POS contracting can have different impacts, depending on the types of agency. They identify three types:

1. The traditional social services agency with its own clearly defined mission, which may have substantial endowments, offer many services, and thus be less dependent on government funds or on demand for any one service (e.g., a Children's Aid Society or a Catholic Charities Family Service).

2. New agencies founded in the past three decades in response to the availability of government funds in special areas such as mental health, substance abuse, and services for runaway adolescents, which may be completely dependent on their government contracts, but have less conflict about mission.

3. An agency established in response to new community needs, such as a battered women's shelter or a hospice for people with AIDS, which may have emerged with a minimum of support, may be dependent on volunteers, and may be seeking government contracts to survive.[5]

Curran points out that legislation may dictate the content of contracts or may specify much of what might otherwise be included in a contract. For example, legislation may specify and require

- open and competitive bidding for all contracts
- acceptance of the lowest bid where quality is considered equivalent
- the contract agency to deliver the service at lower cost than the public agency
- active discouragement of conflicts of interest by government officials who are negotiating and awarding contracts, by prohibiting former government officials from working for contracting agencies for a specified period of time after government employment or restricting officials from contracting with the agencies in which they have a financial interest

- severe penalties for misconduct or fraud in seeking, negotiating, and carrying out contracts
- cancellation of contracts for good cause or for budgetary reasons
- universal access and nondiscrimination in serving clients
- job security for civil servants whose jobs are eliminated by the contract
- evaluation of contract services and monitoring of performance
- oversight by a trained government official.[5]

Curran concludes that, whether through legislative provisions or contract specifications, the POS contract must spell out clearly the types of services to be provided, the quantity of each, the qualifications required for professionals and others delivering the services, and the eligibility criteria for the clients. He argues that the contractee has the greatest leverage in the earliest phase of the program's existence; when the market is small, there are few potential vendors, and the public agency has had limited experience in negotiating and awarding contracts. He states that the public agency gains more leverage with time, experience, and a larger number of vendors seeking a contract.

Many authorities consider monitoring and evaluation as critical to successful contracting and an essential part of good contract management. Contract monitoring is a key part of the public agency's responsibility to assess the success or failure of a particular privatized service. In this context, the contract agency should be required also to collect the data that are essential to the monitoring.

Kettl points out that "The great lesson of the nation's now lengthy experience with privatization is that it is *competition*, not the public-ness or private-ness of a program that drives costs down and performance levels up" (emphasis added).[6] Sclar agrees that much of the literature stresses the importance and desirability of competition, but notes how rarely true competition exists in many situations where government has moved to contract. The major exception is the "classical," "arms-length" contract involving "creation of highly specific deliverable output in a tightly specified time frame." Often the reality is an "incomplete contract" and with a longer indeterminate time horizon with some need to adapt to future contingencies and a mechanism to settle disagreements. Even more appropriate to

our subject matter in Sclar's view would be a "relational contract," transforming the pattern "from a market-based arrangement into one rooted in interorganizational trust."[8] Such alliances are not systematically forged in a bidding war.

Moreover, even where there is competitive bidding initially, it is likely to have disappeared when the time comes to renew the contract. U.S. Government Accounting Office (GAO) staff (interview) observe that even if a competitive environment exists for hard services, the number of qualified bidders for social services may be limited in certain circumstances, such as when the contracting government agency is located in less urban areas or requires highly skilled labor. In the social services field, one is much more likely to be dealing with oligopolistic situations than with competition. Relatively few social services agencies provide particular specialized services, and thus the likelihood of finding real competition for a given service is doubtful. Furthermore, given the high cost of entry in a field providing services to hard-to-reach populations, sole-source contracts or limited competitive bids are more likely to be the norm than full competition and open bids.[9]

It is not clear that most CBOs are able to cope with the requirements of the contracting agencies.

The largest complaint about the POS contract is that it can create perverse incentives: continuing to provide a service that is reimbursable when the service should have changed to one that is not or one that is reimbursable at a lower level (from foster care to family reunification; from child guidance treatment to a group socialization program). There is no financial incentives to rush to "permanency," whatever the national policy; indeed, the agency budget is stabilized if foster care beds are kept occupied. Although we have no systematic data about whether and how often the wrong consideration actually enters or prolongs the service pattern (there is an inevitable temptation for public figures seeking publicity to rush to blame), it has long been clear that the child welfare service system does have major problems. Children do remain too long in temporary out-of-home arrangements, neither returning to their families nor being freed for adoption, for example. There can be no surprise at the interest in "performance-based contracting" and in "outcome" standards as measures of contract fulfillment. Efforts should be made to redirect practice. These new orientations in POS contracting result in a convergence of POS

contracting and managed care, where they are basic. Indeed some POS contracts now also incorporate risk-sharing, central to managed care.

Currently, among the other recommendations scholars and analysts have urged regarding successful POS contracting (and which we regard as advice to consider with regard to our task) are the following:

- Define the public agency's mission clearly to clarify which services to privatize and why.
- Set uniform standards for accountability, so that feedback and evaluation can provide the basis for designing better future contracts.
- Ensure sufficient flexibility and discretion to permit innovation at the same time.
- Provide multiyear contracts to ensure continuity of services.
- Issue RFPs that include specific performance and outcome expectations.
- Select appropriate vendors that clearly have the needed and relevant expertise.
- Have trained professional contract management staff who know both the substance of the service and the contracting process.
- Develop incentives for the contractees to meet program goals in a cost effective and timely manner.
- Develop clear compensation measures.
- Negotiate flexible compensation measures that are closely linked with specific program objectives.
- Specify what the contract agency is to provide and how it will be demonstrated—for example, which services are to be delivered, to which population groups, with what expected results, and in what time frame.
- Try to establish compatible rather than separate and inconsistent budgetary periods.
- Establish criteria and procedures regarding consumer rights.
- Develop monitoring and evaluation procedures that will ensure that contract terms are implemented.
- Establish payment rates and risk-sharing arrangements.[11]

3. Managed Care

As we ended the first stage of our exploration of child welfare privatization in 1998 we wrote, "Given the growing concern with management problems and the importance of contract specifics and capacity to assess performance and outcome measures, it should not be surprising that a new approach to contracting via tighter management has caught the eye of public officials and child and family social service professionals."[1]

The new approaches—the plural is deliberately chosen—are being grouped under the managed care rubric but, as we shall note, represent a range. Those who analyze and advocate managed care tend to stress three of its features:

1. There is a *prospective payment*, some kind of case fee or capitation rate, which follows the case or all cases that might arise in a given domain or a period of time.

Financial control techniques include prepayment for a complete service package to a provider, and financial risk transfer to a client via deductibles and/or co-payments. Prepayment for a service package as opposed to a fee for service or item/intervention by intervention billing usually involves a capitation or case rate methodology. Though computed on a per capita basis, both of these methodologies involve paying for serving a population group rather than an individual. A capitation strategy asks the organization to provide a specified service package to a target population regardless of whether or not they use the service. Since it is hard to estimate what the cost of care will be for an entire population, prepayment methods often employ a case rate methodology, whereby the organization receives a fixed fee for each patient based on the average cost of utilization for people in their severity or disorder category experienced by the organization in previous years.[2]

2. There is some *management of entry into the service system components*—a gate-keeping function—whether approval of initial entry alone or also approval to enter specialized or different levels of service. This mechanism may be oriented to controlling costs but also may serve to integrate the services around the case to achieve effectiveness–efficiency. The latter is sometimes its primary purpose.

3. The efficiency–effectiveness objective also tends to add to the managed care system provisions for *performance monitoring and outcome targets.*

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Thus the contracting agencies need to live within their prospective payments, function as per contract specifications (following case protocols, for example) and on average achieve satisfactory results if they wish to do well financially and remain in the system. Control over access and utilization and prospective payments change the incentive system from those under fee-for-service or per diem rates to incentives compatible with the specified process or outcome goals of a health, behavioral health, or child welfare system that has gone in this direction. But there is the risk that the ending of a fiscal motive to hold on to a case may put in its place an incentive to shorten or limit service or treatment even where this is not constructive.

Managed care began in the medical field, its place of origin, out of a desire to improve quality by creating a primary care, case coordination, and gateway system to improve the quality of services and to do this economically with prospective payments. One premium payment to a health maintenance organization (HMO) would cover primary care, specialist services, and hospitalization as needed. The system had incentives to offer preventive services (check-ups, inoculations, nutrition counseling) so as to cut its costs from acute and chronic illness. There were many nonprofit and for-profit HMO success stories, to the point that employers were mandated to offer the HMO option to ensured employees as a plus, because it usually was free of deductibles and copayments.

The medical cost inflation of recent decades changed some of the incentives for some employers and HMOs. Managed care can also be used to make access difficult and case coordination minimal, so as to limit costs. It can be a way for the employer or insurance company to buy coverage at a negotiated rate, which cuts the managed care organization's (MCO's) profit margin substantially. Then, the management of care becomes a mechanism to minimize service use, and it loses its integration functions. As the Congress and the White House attempted increasingly to control federal health spending, managed care became first an option and then a preferred system for Medicaid. Finally, it also became a Medicare option: a recipient could have his or her entire HMO fee paid by Medicare and thus avoid the copayments and deductibles. All of this did decrease public costs, but of course there are some other elements in the unsolved medical care financing problem, and there are some trade-offs, for example, the declining quality of care reported in some cases.[14]

The medical cost inflation has also affected the employer insurance market, the major source of health insurance in the United States. Employers held the line, then tried to bargain for limited premium rises, often turning to preferred provider organizations, a new option, and other new entities with which they could bargain. Eventually, some dropped employee dependents or asked employees to pay or share costs of insurance for their families. Insurance benefits were made less generous. Also, policies were changed to increase copayments and deductibles and then—whether under traditional policies or employer self-insurance—managed care procedures were added: pre-authorization for all but the primary care medical contacts, second opinions, and all but emergency surgery and also denial of services not seen as "medically necessary."

By now for many HMOs there is no longer the earlier culture of service, coordination, and prevention. For them and for some insurance companies, it is story of access control and attempts to survive with limited capitation income. Some have lost money and curtailed some programs. In the public mind HMO or insurance policy managed care can be seen as a constraint or denial mechanism. The realities of abuse have generated efforts in both national political parties to enact a patients' bill of rights.

How, then, does managed care become in some places an acceptable and in others even an attractive mechanism for current child welfare reform? The pathway has been through the psychiatric service system, now often referred to as "behavioral health." That development came out of two streams:

1. Employer medical insurance policies often include coverage for mental illness, and public clamor, as well as congressional action in 1996, have insisted that where there is health insurance it must treat mental illness no less generously in expenditures than it does physical illness. Inevitably the cost concerns led to the managed care solution. Insurance companies began to "carve out" the mental illness components of their policies and to contract with behavioral health MCOs that would, in turn, contract with, employ, or acquire psychiatric care facilities, congregate residences, clinics, and individual clinical practitioners. Following a period of mergers and acquisitions this is now a large industry with some large firms and a few giants. The process continues.

2. For some decades, child guidance clinics, child welfare agencies, and children's institutions in various parts of the country have sought to define themselves

as mental health facilities, chiefly to qualify for Medicaid payment for services to eligible children, but also because it was seen in some quarters as signifying higher professional status. To qualify they built into their service delivery plans medical–psychiatric surveillance of their diagnoses and treatments. By the 1990s such arrangements were common. The child welfare system, both its public and its private sectors, now relies on substantial Medicaid funds where the intensive service in the community or the use of a congregate facility can be designated as a mental health service. By now this is defined with reference to the standard psychiatric classification system *(DSM-IV)*, but the classifications are hardly precise. Most of the RFPs to which we refer subsequently ask bidding agencies whether they or a subcontractor qualify for Medicaid reimbursement. New York's largest voluntary sectarian child and family agency receives commercial insurance payments for half of its clinical managed care budget and Medicaid reimbursement for 40 percent.

The new approaches being grouped under the managed care rubric represent a range.

It was this behavioral health connection and the behavioral health move to substantial managed care that made the efforts at a child welfare adaptation predictable. Many child welfare clients are Medicaid eligible. Medicaid is billed for medical services for many children in foster care. Even the responsible federal authorities (Health Care Financing Administration, or HCFA) have encouraged the inclusion of child welfare in Medicaid managed care contracts with some state governments for behavioral health, or the creation (carving out) of separate child welfare mental health managed care arrangements, so as to allow careful validation of claims (are they being billed for child welfare services, which are not mental health?) and to control costs.

As we explored contracting in child welfare, it was inevitable that we would look at the most discussed and promoted new administrative and financing devices, many of which are characterized as managed care or as adapting managed care tools. An early survey by the Child Welfare League of America (CWLA) reported that 38 states had involvement with managed care programs, pilots, experiments, and explorations. A subsequent 1999 survey listed 28 states, but the managed care definition is loose (including what are essentially instances of new privatization).[15]

Although a CWLA Managed Care Institute was established to explore this development, they appear to be promoting managed care as inevitable and desirable, and they have joined with a private for-profit behavioral health managed care consultant service, Open Minds, in an influential marketing campaign. (Behavioral health for serious cases is now managed care for 30 percent of cases "and it appears children's services are next." "Social service managers have to overcome the notion that managed care... will go away."[36]) Perhaps the CWLA is reflecting the importance of Medicaid reimbursement to some of its members and its increasing interest in behavioral health as manifested by the recent affiliation with the American Association of Psychiatric Clinics for Children.

The GAO found child welfare managed care projects or initiatives implemented in 13 states and initiatives under consideration in 20 others. Mostly included are foster care and the other most complex and costly child welfare services. However, thus far "only about 4 percent of the nation's child welfare population is being served under managed care arrangements."[37] Most of the contracts are with experienced nonprofit social services organizations already serving the communities. There are some for-profit service providers and MCOs. This might be described thus far largely as managed care in the service of local reorganization.

The GAO classification of reported developments is informative: 10 of 36 relevant sites are public agencies incorporating managed care elements in their contracts and practice; 19 are "lead agency" plans, networks that do not necessarily require managed care, as we shall argue; there are four contracts with for-profit MCOs and three with administration service organizations. Whereas the CWLA's 1999 report listed 44 managed care and privatization initiatives in 27 states (many are small pilots and explorations), 25 of these are lead agency network plans (see below), which can be classified as readily under POS contracting as under managed care.[38]

As part of our preparation for this guidebook we reviewed the literature available, including research, and we interviewed experts. We completed four case studies of the sites and jurisdictions furthest along and "touched base" with six others, covering their planning documents, RFPs, and contracts and interviewing leadership, mostly by telephone. Subsequently checking GAO and other published reports, we note that we had not missed important, relevant initiatives.

Our interim findings are drawn upon in the four guidebook sections (Chapters 3, 4, 5, and 6) that follow this chapter.

4. Networks

The review of significant current developments needs to be rounded out with reference to current interest in networks. What we found in Los Angeles and on a smaller scale either in existence or sought in many places is an operational system in which a central authority contracts with a lead agency, which in turn creates a self-sufficient service network by subcontracts and agreements. Los Angeles is only partially developed in the sense that this schema exists for two parallel service systems, family preservation and family support. Local community groups were asked to come together to designate lead agencies. Combining what it could offer with what subcontractors could do, the lead agency created a comprehensive service network for the community for which it would contract. Foster care is not yet covered by this approach, but the department is wedded to the Casey Family to Family model, which is congruent with the schema. Intake, child protection, and case management remain with the public department.

While Los Angeles serves here as an exemplar for the recruitment of lead agencies and construction of a network (see Chapter 4 for further detail), one would not propose separate networks for family support and family preservation or leaving foster care out of the delivery design. What occurred in Los Angeles has historical–political explanations and the need to complete the plan, at least by including foster care, was well understood at the time of our review.

Elsewhere lead agencies have received contracts for a network of residential care and aftercare services for youth in state custody (Commonworks in Massachusetts with six contract agencies and a provider network of 150) or what are called "residential continua of care" (15 contract agencies in Phase 1 of Tennessee's contracting plan).

The GAO identified network creation as the lead agency form of managed care and found it, as noted, in 19 of the 30 initiatives. It dominates the 1999 CWLA listing. Child welfare experts will immediately recognize the network as an old idea in the tradition of service and program integration and as responsive to the calls for a "seamless" service system that is community based. Its point of

departure need not be the privatization or economy–efficiency motivation of POS contracting or case management. But if combined with a capitation rate or a case rate, it can support a managed care system. Sclar stresses the importance of flexibility, trust, and mentoring in successful network systems and considers these as part of "relational," as contrasted with classical or typical neo-classical contracts. The traditional contract is detailed and inflexible. The relational contract is "incomplete," involving intensive personal relationships and contract readjustment for contingencies. If managed care is based on a typical arms-length classical contract, will it lose the needed relational qualities?

A broader political science exploration of networks in many fields and countries in fact distinguishes them (perhaps incorrectly) from contracting out, because it considers them to be "horizontal partnerships" of coequals without government control. The child welfare networks based on lead agencies or MCOs are not quite that but do stress "collaborative" management styles.

5. What Does One Conclude?

As noted in Report I we found a considerable interest in child welfare managed care. However, just as there is no clear-cut empirical case to argue for privatization over public operations from the point of view of the usual economy–efficiency debate, one cannot (with the limited experience available) point to outcomes in choosing among POS and managed care models, despite enthusiasms of some observers and some tendency for managed care technology and vocabularies to invade POS.[1] Moreover, we have found the new networking developments to be very important to delivery reform.

In the light of the current picture, we see our task as helping contractors remain "mission oriented," not to permit important child welfare reform impulses to be sacrificed to the centralizing and cost control impulses of for-profit or nonprofit MCOs, yet not losing the value of outcome-oriented contracts, efficient management, and the innovative management information systems that they require.

The essence of the wisdom of the repeated lessons is straightforward.

- Understand the service fully.
- Develop good performance measures.

- Understand the underlying economics (i.e., cost and production).
- Construct contracts that "align risks with incentives."
- Provide enough time to plan the process of change.
- Consult with all the relevant players and stakeholders.
- Acknowledge the need for a strongly committed top-down leadership to make changes happen.
- Acknowledge the importance of a bottom-up approach to the service if we hope to be effective.

But there are some dilemmas: There is no validated basis for labeling *specific* things "best practices," because these new initiatives in the varieties of enhanced privatization and the many things being called "managed care" have not yet shown the degree of their impact at the client and case levels. Even the few that may be more systematic and further along are one of a kind, so that one cannot sort out the critical variables.

We here offer from our explorations further relevant detail with regard to experience to date (more will follow in Chapters 3, 4, 5, and 6). First, given the public responsibilities for child protection and the public accountability for implementing state and federal policies, it occasions little surprise that so-called managed care initiatives in child welfare thus far almost always involve the public agency as the MCO. There are some exceptions in contracting for administrative services such as technical assistance, or for a management information system, or for training. The few for-profit MCOs are not generally comprehensive: They involve what are called "deep-end" cases, usually with regard to residential treatment. Even in Hamilton County, Ohio, where Magellan Public Solutions, a private for-profit organization, undertook early in 1998 to manage child welfare, mental health, and addiction services, the Department of Human Services remains responsible for basic protective services and foster care and refers placements and "deep-end" cases to Magellan, which then carries on.

A contractee that accepts a capitated payment or agrees to produce pre-agreed results (as measured by pre-agreed performance indicators) is assuming a risk. It could "earn" profits beyond its costs, but it could have losses. A contractor that

agrees to payments that could go well beyond contractee costs, if the volume of use or the depth of services is well below its predictions, is "wasting" public funds. Yet the introduction of such risks is of the essence of managed care. The agreement to share risks should result in careful analysis of relevant experience and is expected to create sound motivations for efficiency and effectiveness.

The range in current contracts is from complete capitation and full risk sharing to "no-risk" fee-for-service contracts. Some allow a small number of cases to be kept out of the risk system because the risk is especially great. Some offer ceilings and floors to partially limit risk, recognizing that both public agency and providers now need to take decisions on the basis of cost experience under the old system and inexact estimates of the potential effects of changes they plan to make. Perhaps the situation will be clarified a few years down the road, but the analogy of medical managed care is not encouraging.

One cannot point to outcomes as a guide for choosing among POS and managed care models.

Wulczyn and Orlebeke, whose four case studies included one site that we did not cover, offer the following helpful analysis of risk policy (note that their "contractors" are our "contractees"):

- All contractors carried unit cost risk. "Unit cost risk" refers to changes in the cost of producing a unit of service that adversely affects the rate of expenditure in a fixed reimbursement context.
- The public agency continued to carry upside volume risk. "Upside volume risk" refers to the risks associated with larger-than-expected program admissions.
- The contractors continued to carry downside volume risk. "Downside volume risk" refers to the financial risks that are associated with lower-than-expected program admissions.
- With the exception of Hamilton County in the first 18 months, at least some duration and level of service risk has been transferred to the private contractor. "Duration risks" refer to rates of expenditure that exceed expectation because children remain in care for periods longer than expected. "Level of service risk" describes situations in which clients use higher levels of service (i.e., higher unit costs) than expected.[22]

Kansas is much referred to as the only state with a statewide managed care initiative. Relatively expanded reference to it here will illustrate some issues. It is too often not understood that this is a public agency managed care model. The public agency continues to deliver some services, in particular child protective services investigations and case management, a pattern we found in most places said to be beginning or trying or implementing managed care. It is privatization in the sense that although a considerable portion of Kansas child welfare (and of U.S. child welfare generally) has long been delivered by private, nonprofit agencies on the basis of subsidies or POS contracts, this new plan created an enormous expansion of the voluntary child welfare sector, using pooled public funds. It is a top-down initiative, with leadership coming from the state, and major large-area voluntary sector agencies winning delivery contracts (which they, in turn, share with subcontractors).[1] What makes this managed care, perhaps, is that Kansas is the first state to undertake a capitation plan in a risk-sharing child welfare delivery system. To the (now former) Commissioner, the Kansas model could be described as "management by outcomes." The agreements are based on outcome measures; unlike managed care plans, outside managers do not control entry to the service system. In theory, all of this could have been achieved by reorganizing, expanding, and upgrading the public department and reorienting staff through training, but that was not politically possible. The legislature wanted radical change and did not want the public agency expanded. It found privatization and contracting with the voluntary sector for service delivery attractive. Indeed, the notion of "results-based" contracting is attractive to many people, as it is to us.

Given both the federal permanency goals and the thrust of the almost omnipresent court orders and consent decrees, state agencies have built into their contracts specific statistical performance measures such as (but not limited to) the following:

- the amount of abuse or neglect experienced by children in placement
- the frequency of re-placements following referral to a provider
- the extent to which children are kept with siblings

- the percentage of children returned to their families within six months of referral
- the speed within which adoption agencies place children with adoptive families following receipt of an adoption referral
- the extent to which participants express satisfaction in responding to surveys about their experiences with these various processes.

What is success? The specific statistical objectives built into the contracts come from experience, court decrees, staff judgment, or "out of the air." The process goes back to the "management by objective" strategies of the Nixon administration. Most of the targets appear feasible, even easy; some are being met, and others not in the places that have specified them. The more complicated and subtle work in measuring outcomes as family or child development being done elsewhere in research settings is not yet reflected in the programs that we have reviewed.

What is the price? A new process is called for in all of these approaches involving a changed practice, often a more specialized staff, perhaps different channeling of children. Although some of the contracting permits funding negotiations, agencies sometimes must bid on the basis of a likely case volume computed from prior state caseload experience and their view of the expected service process. In other instances (Colorado), the legislative objective from the onset was to save money. It allocated fixed sums to the counties to meet their statutory responsibilities and then gave them enhanced flexibility to develop delivery systems, including managed care via a public or a private entity. The counties, which now pay 20 percent of child welfare costs, will keep all savings except for 5 percent, which is to be returned to the state. This system is understandable politically but hardly a formula for improved services.

We could describe in more detail the issue of built-in targets and estimated costs but what has been said is sufficient to lead to the point that contractor and contractee need to be careful. They are sharing risks, yet they lack needed information to assess the risks fully. Some potential contractees withdraw. Others are not free to experience the excitement, innovation, and creativity that the process calls for. Depending where the burden of risk lies, it may tempt the contracting agency into a pattern of micromanagement, which is dysfunctional.

All of this would appear to make some of the initiatives seem premature or ill-prepared, despite the heroic efforts behind the request for information (RFI) and RFP writing, the agency proposals, and the evaluations of bids about which we have learned. As much could be said about the logistics of staff-building. In effect, taking no responsibility for the skillpool, public agencies call for bids. They usually do ask for information from the agency in the application about staff but, except for those instances in which existing providers are merely expected to serve at existing volume but under new contract terms, the successful providers or managed care bidders need more staff. They may need to provide services not known in the community or to upgrade services, so they cannot rely on staff "released" by the public department by the shifting of responsibilities. Clearly if the public sector wants to make it all work well, it must itself develop an adequate plan that will supply the needed trained staffers. This should not be left to for-profit MCOs or to private service providers during an implementation phase—but it often is.

Managed care initiatives in child welfare thus far almost always involve the public agency as the MCO.

The centralizing tendencies of managed care are clear. Without centralization it is difficult to achieve utilization and cost controls. This is not necessarily fully compatible with the devolution and turn to CBOs as expected in the child welfare reform agenda. Of the places we studied most closely, Los Angeles stressed CBOs as the hub of its network system, but case management and much service still resides in the public department. Kansas, a rural state, does not have a residential pattern likely to sustain CBOs. Hamilton County, Ohio, has expressed interest in decentralization but for the moment is limited to several sites for client contacts other than the main office. We were told that its for-profit MCO has not factored the neighborhood into its placement planning. But their bid was not evaluated from this perspective.

Managed care also has a distinct bias for large size. The actuarial predictions on which risk payments are set follow the "laws of large numbers." Small providers, especially CBOs, cannot hedge their risks.

Iowa also reports some informative experience. This state has been in the lead in advancing the child welfare reform agenda and is committed to a child welfare system that is "community designed and managed in partnership between the state and its communities," is based on "decategorization," and emphasizes "finding means to fund and support long-term prevention efforts without diverting funds needed from early intervention services" and also "involving consumers throughout the system." Issues had arisen about the substantial components of child welfare billed to Medicaid as treatment and rehabilitation. The state has a Medicaid managed care system and sent out an RFI for a new combined Medicaid, mental health, and substance abuse program (1996). Without specifying details, we note that a substantially negative public reaction to the RFP led to a second version. HCFA too was negative, because they believed that they were perhaps improperly billed for social services that did not qualify as mental health rehabilitation. The second RFP, which incorporated child welfare, also received a negative public response—even though the state expressed an ultimate goal of a community-based system for managing children's services. The legislature sponsored a public forum (late 1997), subsequently a work group produced an interesting report early in February 1998, and the state is attempting to meet HCFA concerns by an interim plan to estimate the percentage of child welfare services to be legitimately charged to Medicaid (a strategy that was offered by HCFA officials). Child welfare is excluded from the managed care mental health–substance abuse RFP for the present. The long range commitment is to move within the next two (or three) years to a "child welfare juvenile justice system that would be publicly managed at the local community level." Several pronouncements from state leadership about what was behind the strong Iowa response to the pressure for statewide child welfare managed care sums up three themes that we believe need to be conveyed: Mary Nelson, administrator of Iowa's Division of Adult, Children, and Family Services, said of the public reaction to the managed care RFP incorporating child welfare:

They were concerned that a lot of years had been spent encouraging community involvement, partnerships and a sense of ownership around the child welfare/juvenile justice system and this would undermine community decision making.

The work group said,

The state has specific legal objectives under child welfare and juvenile justice regarding safety, reasonable efforts, least restrictive environment, best interests of the child, and permanency that cannot be transferred to a contractor *(emphasis added).*

And, finally,

The workgroup made an important distinction between adopting managed care tools and strategies to manage the system within finite resources and contracting with a managed care organization.

In this connection it is noted that much of the needed technology does not yet exist; that managers and staff need time to develop relevant skills and expertise; and that those managed care strategies that use a medical model (study–diagnosis–treatment) are not applicable to all child welfare and juvenile justice. Both in child welfare and in juvenile justice, agencies undertake some interventions that do not necessarily assume that the problem resides in the individual client or family. Iowa is at work on plans to protect decategorization and local decision making for all this while using a managed care structure. As Charles Bruner sees it, the "tools and strategies of managed care are what you would want in a well-managed system." We hear this from people in a number of places who, nonetheless, see a public MCO as central. Current buzzwords ("managed care") aside, this means that a public child welfare agency can and should adopt whatever management technology has been developed to advance efficient, effective, and goal-accountable services.

Having elected to take a neutral stance as to privatization and managed care, which in many places and ways become "givens," and having chosen to focus on assembling what guidance we could for those who elect to offer public contracts or to respond to offers, we have bypassed some of the philosophical and political issues that managed care raises. Here we mention several of these briefly as we move on, both for completeness, because some policy makers and providers may want to ponder them before they act, and to provoke useful public debate.

First, there are those who fear that voluntary social agencies will not survive the new competition from for-profits, being too small and lacking the capital to

compete in risk-taking and expanded tasks with the large for-profits. This concern arises from behavioral health and job programs, not yet from child welfare managed care. Those who hold it note the importance of the voluntary social agency as an activity arena for citizen–volunteers, as a vehicle for protecting societal diversity, and as a precious component of civil society. We shall not elaborate.[5]

The immediate reactions of agencies have been mixed. Some of the large traditional voluntary social agencies and their friends and supporters respond to developments with fear, disappointment, and anger—and some with positive anticipation of opportunity. Thus far most child welfare agencies are not threatened by displacement by for-profits. But others are given pause by the reminder that there is already considerable public money in the voluntary sector, enough to challenge the tax exemption. They also have heard proposals that employees "purchase" the agencies, privatize completely, and convert to for-profit status. In a related move, we observed over a year the executives of an exemplar children's agency beginning to think more like CEOs in a market enterprise out of self-protection, among other things, spinning off a for-profit provider.

Some analysts, executives, and planners see a poor child welfare fit with managed care per se. One observer said to us, "Managed care made sense in the medical field because there was excessive expenditure to be squeezed out. But why child welfare, a field with problems because it is badly under-resourced?" Another commented, "Managed care in child welfare is the story of an under-resourced entity trying to solve its problem by reorganization." Although these comments from opposite ends of the country convey considerable truth, and while the voluntary sector needs in a basic sense to get its bearings, we do not believe the managed care impetus will therefore end. We do not believe that all new technology will be readily dismissed. We see in managed care many tools and strategies that probably could serve a well-managed delivery system: The caveat is that the experience with child welfare managed care to date has been limited in scope and time. Without a firm research base as we offer a guidebook, we rely on "face validity," testimony, management tradition, and "wisdom" to help interested parties think about RPFs and contracts and to shape their own choices.

Nor are we sure that one must or can chose between the POS contracting and managed care strategy, because we also have learned that each rubric as it has

evolved can draw on the idea of networking: they are sharing performance and outcome contracting, case fee and capitation agreements, and other risk elements as well.

As to how to name the process, we again quote from the clearly formulated Wu czyn–Orlebeke document, which was not available until after we had completed our own case studies, with similar conclusions:

From the results of our study, two conclusions can be reached. First, child welfare officials in all sites were concerned fundamentally with the alignment of programmatic goals and fiscal incentives. The majority of individuals interviewed expressed concerns about the lack of program flexibility brought about by rigid categorical funding tied to the placement of children in out-of-home care. To the extent that managed care is a vehicle for aligning program funding with program objectives, these sites can be said to be applying managed care principles to the delivery of child welfare services. Nevertheless, the term managed care is not sufficiently descriptive of the actual programs being implemented in the four sites we studied. As is the case in health care and behavioral health care, managed care represents the fusion of programmatic/service reform with fiscal reform. Since many of the underlying issues are parallel to those observed in child welfare, managed care is a serviceable term, but it does not substitute for a thorough understanding of program and financial details.[4]

Notes

1 Part of this section draws on Report I of this project, Sheila B. Kamerman and Alfred J. Kahn, *Privatization, Contracting, and the Reform of Child and Family Social Services* (Washington, DC: Finance Project, 1998). That report is based largely on interviews and a review of published literature, special reports, working papers, and newsletters. This section supplements all of the above with what we learned in a subsequent series of in-person case studies as well as exploration via telephone interviews and review of major documents of almost all relevant state initiatives.

2 For detail and documentation, *Ibid.* For federal, state, and local "shares," see Rob Green, Shelley W. Boots, and Karen C. Tumlin, *The Cost of Protecting Vulnerable Children: Understanding Federal, State, and Local Welfare Spending* (Occasional Paper No. 20, "Assessing the New Federalism," Washington, DC: Urban Institute, 1999).

3 Sheila B. Kamerman and Alfred J. Kahn, eds. *Privatization and the Welfare State*, (Princeton University Press, 1989). Also Elliott Sclar, *To Market, To Market: The Economics of Privatization* (Ithaca, NY: Cornell University Press, in press).

4 Report I, pp. 11–12.

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[5] Michael Lipsky and Steven Smith, "Nonprofit Organizations, Government, and the Welfare State", *Political Science Quarterly*, Vol. 104, No. 4 (Winter 1989–90), pp. 625–645.

[6] William J. Curran, "Privatization and Human Services Contracting: A Legal Review", in Margaret Gibelman and Harold W. Demone, Jr., Ed., *The Privatization of Human Services: Case Studies in Purchase of Services* (N.Y.: Springer Publishing Company, 1998) Vol. 2, pp. 183–201.

[7] Ibid.

[8] Donald F. Kettl, "Privatization as a Tool of Reform", *The Lafollette Policy Report* (Madison, Wisconsin: University of Wisconsin) Vol. 7, No. 1, Fall, 1995.

[9] Sclar, *op. cit.*

[10] Kamerman and Kahn, *Privatization, Contracting...*, p. 20

[11] *Ibid.*

[12] *Ibid.*

[13] S. P. Segal, "Social work in a managed care environment," *International Journal of Social Welfare*, Vol. 8, No. 1 (January 1999), p. 48.

[14] *New York Times*, June 3, 1999.

[15] Charlotte McCoullough and Barbara Schmitt, "Over half of states have child welfare managed care or privatization initiatives under way: Results of 1998 CWLA Managed Care Institute Tracking Project," *Children's Vanguard*, April 1999, pp. 4–8.

[16] *Children's Vanguard*, January 1998, p. 8; September 1998, p. 6.

[17] U.S. General Accounting Office, *Child Welfare: Early Experiences Implementing a Managed Care Approach* (GAO/HEHS/99-8, Washington, DC: U.S. Government Printing Office, 1999). See especially pp. 3–4, 28–29, 41.

[18] McCullough and Schmitt, *op. cit.*, pp. 7–8.

[19] Regarding our use of site illustrations: We frequently, in the remainder of this report, mention a specific place or cite sections from an RFP, a contract, and so forth. Our purpose is not to evaluate but rather to illustrate so as to clarify a point or make an approach more visible. There are many claims of accomplishment and many critiques of most of these initiatives, but balanced evaluations, covering reasonable time periods, are not yet in. Moreover, each site has evolved since the time of our exploration. Our guidelines reflect these facts, as readers will note.

[20] Myrna P. Mandell, Ed., "The impact of collaborative efforts: Changing the face of public policy through networks and network structures," *Policy Studies Review*, Vol. 16, No. 1 (Spring 1999), pp. 4–147.

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[21] Thus a University of South Florida survey enthusiastically lists "Initial Positive Findings" after reporting 25 state initiatives of significant size which are called "managed care" (Having shared data with the CWL survey above). However the report shows that only 4 sites had a year of experience; most sites were only planning or beginning implementation; and, at most, sites yielded descriptive program information not data about impact on service delivery or outcomes for children and families. See S.A. Pires, M.L. Armstrong, B.A. Stroul, *Health Care Reform Tracking Project: Tracking State Managed Care Reforms as they Affect Children and Adolescents with Behavioral Health Disorders and Their Families* (Tampa, FL: Research and Training Center for Children's Mental Health, University of South Florida, 1999).

[22] Fred Wulczyn and Britany Orlebeke, "Managed Care and Fiscal Reform in Child Welfare Services: Four Case Studies, Executive Summary" (Chicago, IL: Chapin Hall Center for Children, University of Chicago), October, 1998 draft, p. 5.

[23] Family preservation services covering all state regions, were contracted to 5 agencies, adoption services to one agency, and foster care to 3. Each has sub-contracted with other providers (30 for family preservation, 12 for adoption and 100 for foster care). Few established providers are left out. Many subcontractors serve more than one contract, somewhat facilitating collaboration across program areas, but case management remains the public agency's responsibility.

[24] Dennis W. Felty and Marshall B. Jones, "Human Services at Risk," *Social Service Review* (June, 1998), pp. 192–209. William P. Ryan, "The New Landscape for Nonprofits," *Harvard Business Review* (January–February, 1999), pp. 127–136.

[25] Wulczyn and Orlebeke, *op. cit.*, p. 7.

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3. Getting Started: Public Authorities and the First Decisions

Each state has a designated department that is responsible for its child welfare program. Initiatives to increase privatization in a major way and decisions to use the purchase-of-service (POS) mechanism more or to embark on managed care initiatives will come from or to that department, as will plans for network construction. Often the action is occasioned by decisions of the governor, instructions from the legislature, or recommendations by influential providers and interest groups.

The motives, as already suggested, will vary: concern with child welfare costs, a determination to downsize government via privatization, concern with child welfare problems that have aroused public concern (reports of child deaths or horrible abuse, for example), or inability to meet the program targets set in court decisions or settlements.

If the hysteria of the moment and its built-in "solutions" can be calmed somewhat, then responsible public authorities will want to pause and think, perhaps organize a policy or program planning process to decide which way to go. (It may take considerable effort to reassure those demanding immediate action on a predetermined solution that it would not be wise to forgo a sound overall program.) In one state, the legislature convened a public forum to which it invited all interested authorities, and the forum resulted in a task force whose major report offered guides to substance and process. In several states, governors convened advisory meetings or assigned responsibility to a mixed (inside–outside) task force or committee of department heads. In others, voluntary sector agencies and advocates organized meetings or task forces that addressed recommendations to the state. Then, legislature or governor acted.

There may be many instigators and varied planning processes, which may reflect a state's political culture and traditions, the governor's style, the level of public interest, and the scale of change contemplated. Here we urge only the deliberate choice of a plan for planning. Those who want specific guidance may turn to the extensive literature of planning and community organization or to some of the excellent guides produced by organizations we already have mentioned. Drissel and Brach offer a checklist.[1]

The planning process will be at its best if it involves what current discussion likes to call "stakeholders" in the decision about which way to go. One state decided to convene its public forum only after providers failed to respond in sufficient numbers to two successive variations of a request for proposal (RFP): The design ignored their commitments and beliefs. Two states radically revised plans for pilot projects in managed care when, again, expected bidders failed to respond. Another state proceeded to implementation and then faced the reality that its foster care reform was badly bogged down: The RFP and the subsequently signed contracts were completely unrealistic as to start-up and implementation times. Several jurisdictions found themselves frustrated in dealing with cases in a managed care plan and unable to stick to their budget because juvenile court judges, not committed to the reform, did not accept placement decisions made or insisted on their own (sometimes expensive) dispositions. Finally, one major network effort met considerable difficulty and required much fence-mending because it forgot to consider county auditors' requirements and procedures.

Who, then, should be "involved" in the initial planning, recognizing that the meaning of involvement varies with the process and structure through that the state makes its decisions? The inclusive list that follows grows out of the reports of their processes (or the retrospective self-critiques of their processes) from the jurisdictions that we have explored:

- members or leaders of the state legislature and legislative committees
- county commissioners (or their city counterparts)
- auditors
- juvenile or family court judges
- parents of children who depend on the services
- monitors of court-negotiated agreements or implementation of court decisions
- unions of employee organization or their professional organization
- the service provider community that would be affected and whose active involvement in bidding and, later, service delivery, will be absolutely crucial, including but not limited to—as appropriate to the state or county—foster

home services, residential treatment centers, and other congregate care; day care and early childhood education programs; child health services and "insurance" agencies—including Medicaid and Child Health Insurance Program (CHIP); mental health, substance abuse, and physical rehabilitation programs; parenting and parent education services; and other representatives of related systems whose cooperation and even funding participation may be required in some states: mental health, substance abuse, education, housing, and law enforcement departments.

Obviously, a state planning process that ends in consensus on the part of all these interests will be far along. This is often too much to expect. Different interests have their own preferences and priorities. But a state process will want the consensus of a significant core, and the participation of a broad group of stakeholders will be insurance against missing important issues and considerations.

1. What Do We Intend to Accomplish?

If the answer to this question is not a "given," defined in the charge from governor, legislature, county, the public, or others—or if the answer is rather general—this is where the planner or planning group must begin. What has occasioned the investments of time and money? What will a solution look like?

In current guides to group planning initiatives, this stage is often called "visioning," but it does not intend something ephemeral. Goals need to be clearly formulated and understood, and realistic plans are required. There are many guidelines available as to planning process, but we here outline some of the parameters—particular topics that require exploration, debate, and choices.

2. More Privatization?

The planner will need to begin with some privatization decisions, unless these are predetermined by the body's charge. Despite the increase in privatization of social services since the 1980s, there still are states with significant public delivery capacity; in those states with considerable privatization, the decision may be to further transfer delivery responsibility (and more?) to the private sector, including for-profit providers.

How should a jurisdiction decide? Although there is anecdotal evidence in some places, our own exploration concluded that there is no general empirical

case for or against privatization as judged by the usual economy–efficiency criteria. There are many strong and many weak private and public services and agencies. Nonetheless, there is a strong congressional and state legislative ideological push for privatization on grounds of governmental downsizing or belief that it is more economical or efficient. Some believe that the "private" can best capture religious, cultural, ethnic, or racial values. This may be enough to motivate some states. And the public appears to support the privatization thrust. Many jurisdictions have found ways to protect public employees or to permit public departments to compete for contracts against private companies or agencies.

The incentives to keep beds full or retain cases on the load are cancelled under capitation.

There are also other political considerations. In one state that we explored, there was desperate need to recruit some specialized staff and develop better case assessment, placement, and treatment services, but the state legislature would not consider an increase in numbers of public employees. However, expansion through contracting was deemed acceptable.

Some of the champions of more privatization cite the alleged rigidities of public bureaucracies and the potential for innovation, flexibility, and competition said to be inherent in private systems. (Others ask whether the new accountability machinery, utilization controls, and a search for economy will not have effects that will negate these advantages.) In any case, despite the lack of a firm research base, there is much by way of impressive place-specific rationale and strong preference.

We do not wish to overemphasize privatization or more privatization as an issue. In many states the focus is on new ways of delivering services to children and their families for one or more good reasons. The privatization question is one of many issues en route.

3. Purchase of Service or Managed Care?

The history of social services privatization is a history of direct lump-sum subsidies (the colonial era and the earliest years of the Republic) and then POS or fee for service computed in various ways. States and cities developed their patterns and procedures vis-à-vis their voluntary sectors. Since the 1960s, with the federal government contributing to child welfare funding and then playing a major role,

federal policy has framed state practices. Now, as states privatize further, they have the option of continuing POS practices or taking on the more extensive and ambitious apparatus of managed care.

State planners will want to ask whether the latter approach gives promise of solving the problems that they are most eager to solve. We have already introduced the approach (Chapter 2).

The critical mechanisms are

- a delivery system in which a designated party manages care, e.g., pre-authorizes entry or specific treatments on the basis of pre-agreed criteria
- case management arrangements pointed at coordination or integration of intervention around the case
- a delivery system in which the care options (and thus the services rendered by providers) are defined and described in protocols—and in which, by contract, practice and utilization are monitored
- agreements as to prospective payments on a case basis or for a group of cases that determine the cost to the public contracting agency and the payment to the provider
- the willingness of state agency and provider to accept the capitation fee or case rate as full payment and thus to "risk" some financial loss or to have the opportunity for gain, which (for nonprofits) can be channeled to other service needs or (for for-profits) to earnings (a decision can be made that the experience to date is inadequate to justify a risk component in the contract, while nonetheless inaugurating managed care.)
- provider accountability to achieve predefined outcomes with regard to the various services, with failure probably meaning financial penalties or loss of contract at once or eventually.

Central to these mechanisms are the devices to coordinate services, the interrelated measures to specifically control costs, and the outcome criteria. The incentives to keep beds full or retain cases on the load are cancelled under capitation, other prospective payments, or outcomes budgeting. The monitoring,

utilization reviews, and pre-service authorizations require a tight ship. Risk-sharing keeps all parties oriented to the bottom line.

The advocate of POS could ask whether these market-oriented business controls could not also be applied under a contracting system that does not incorporate prospective payment in its various forms, preferring negotiated fees for various services and contracts in which both sides agree on some volume guarantee. The answer would appear to be "yes." Various types of case integration and accountability developed well before child welfare considered managed care, and outcome measurement or reporting could be part of an evaluation that is or should be preliminary to contract renewal. Risk agreements are not negotiated typically in POS as too dependent on guesses, pending a decent period of experimentation with managed care but could be and now occasionally are.

The advocate of a form of POS that adds some of the devices of managed care face the charge of unrealistic planning. Several decades of case management or service integration under various devices have not often achieved the desired accountability and meshing of intervention, despite periodically publicized notable pilots and demonstrations. Consensus that performance and outcomes should be monitored does not yield visibly increased accountability.

Thus the case for the new strategy—managed care—which seeks to tighten management, shift incentives, cut away waste, and false motions. Thus the substance of the debate as a jurisdiction decides which way to go. But other consideration should also enter.

If treatment is to be pre-authorized by care managers and if protocols are to be specified for each dispositional approach, considerable standardization is assumed. Several questions have come up: Is child welfare sufficiently standardized to support such premises? Can we expect caseworkers to follow pre-set routines for specifically classified cases and to thereby reasonably expect achievement of pre-determined case goals? What if the protocols all existed, were followed, and did not yield the results? What if experienced clinicians could show desirable, if different, results on the basis of service tied to their own assessments and treatment skills that do not match the protocols? Should this be prevented by utilization review and monitoring?

We leave this for serious future research. Contractors and contractees must currently depend on their prior experience. In the longer term, one should expect improved professional practice to refine protocols and outcome criteria.

Further, decisionmaking for standardized and controlled systems requires considerable information about cases, interventions, costs, and outcomes. Risk calculations certainly do. In effect, it is essential to have information about the past as the basis for intervention plans and decisions about risk for the future. Unfortunately, child welfare information systems are currently inadequate. Finally, as explained subsequently, there now are funds and mandates for information systems, and the situation will improve, but an adequate management information system (MIS) cannot be invented overnight because the data must be developed and assembled, then accumulated over a sufficient period to be useful. For many purposes, a state-wide system needs localization.

The responsible state department is accountable for child protection.

None of this argues for or against POS or managed care. Indeed, we observe a continuum: traditional POS, POS plus some enhancement from the new management repertoire, partial care management with the intent to go further in the future (delaying risk until experience and data are assimilated), and a full managed care approach (which—as we note—is not yet operational if one means that all child welfare functions in the jurisdiction are included). We see advantages in the effort at service coordination and alertness to costs and incentives. Therefore, one could encourage state planners to try a design in the middle of the continuum. Here the decision of who will be the managed care organization (MCO) can be critical. First, the network issue.

4. Are Service Networks to Be Part of the Design?

Many of the problems being addressed require a care continuum and a case integration mechanism. Here the idea of "network" becomes attractive. We refer specifically to the idea of contracting with a lead agency which, in turn, undertakes to construct a service continuum with other agencies in its community. The contracting agency many specify who must be covered by the network. This may vary from the full service repertoire required by what the county includes under its family preservation program (Los Angeles), to a full network of out-of-home placement resources (Tennessee), to whatever is needed fully to carry out foster

care or adoption or family preservation (Kansas). That is, the scope of the network varies with the particular pattern of POS or of managed care, but a state could find the device valuable in its search for a delivery continuum and a way of decentralizing monitoring and accountability to the lead agencies. A Texas pilot in Dallas/Fort Worth is using the term "primary contractor," which may or may not signify a network design. Others prefer to talk of the "lead agency" in the network.

A lead agency may be limited by the contract to itself delivering no more than a fixed proportion of the services, so as to ensure adequate utilization of community social services resources, encourage diversity, and protect political support.

Lead agency plans dominate by far all listings of privatization expansion or innovation in the states and neither signify nor deny a managed care "sweep," because they are usually in the middle of a POS contracting managed care continuum. A lead agency may be part of more than one network (Los Angeles), and it may be multifunction, enriching its range and independence.

5. Who Will Be the Managed Care Organization? What Monitoring and Technical Assistance Capacity Is Needed?

To our considerable surprise, given the reports of a major movement toward managed care, we found—as already noted—that public agencies have in almost all instances placed themselves in the new child welfare delivery system as the MCO. They were not contracting out full responsibility for child welfare as an employer does in turning over to a health maintenance organization or insurance company responsibility for full medical service to covered employees. That is, the public units still investigate abuse and neglect complaints and accept case referrals, make case assessments, develop plans of action, take cases to court as required, and then refer to contract agencies or networks or managed care placement organizations for ongoing service. This, on reflection, should occasion no surprise. The responsible state department is accountable for child protection. As noted in Chapter 2, an Iowa work group concluded that

> *the state has specific legal obligations under child welfare and juvenile justice regarding safety, reasonable efforts, least restrictive environment, best interests of the child, and permanency* that cannot be transferred to a contractor. *(emphasis added)*

The holders of this view—and thus far they are the majority of the innovators that we have encountered—contract for provider services, favor many or all managed care tools, but intend to preserve a strong, if diminished, public agency at the center of the system. There is not however complete consensus on this point. In theory, a state or county could turn the entire system over to a for-profit MCO, as it has done in some behavioral health managed care contracts. The legal issue suggested above will eventually require testing in the courts. The service delivery question will require more experience.

A managed care contract agency also will need to specify in its bid how it will monitor service delivery (are protocols followed, are time limits and specific milestones followed, are pre-defined outcomes being achieved?) But the contracting public department, whether in its role as contract manager or as the continuing MCO, will also require ongoing monitoring and technical assistance capacity to be effective in relationships with providers. Experience is beginning to accumulate.

Los Angeles County, in the POS pattern, signs contracts with lead agencies that in turn subcontract with others to create community networks covering a specified array of services, in what is defined as the "family preservation program." However, the county child welfare department retains child protective services as its responsibility, so that the contract agencies receive referrals for designated services on one of three predefined levels of intensity and price. County protective staff retain case management responsibility and also make monthly home visits, as part of their accountability for child protection. (For the time being, the county office also administers foster care; another network system implements a family support program.)

In the managed care pattern, Kansas contracts for foster care (three agencies), family preservation (five agencies), and adoption services (one agency). Each, in turn, subcontracts to make full use of the state's service resources. Almost 150 agencies actually offer services growing out of the nine basic contracts. The state department continues with the child protection and assessment roles to the point where cases are referred to one of the systems for its specialized services, referred outside of child welfare, or terminated. Apart from freeing the state to increase substantially its concentration on its protective role, the plan frees states for an inventive monitoring and technical assistance role as implemented by a contract

manager for each of three major programs and an area contract specialist for each program in each of 12 program areas (total 36). A deputy commissioner is the 40th member of this accountability and quality control team, which also offers technical help.

In a third pattern, Hamilton County, Ohio (Cincinnati), is one of the few places to date to contract with a for-profit organization (Magellan Public Solutions, or MPS) to manage child welfare, mental health, and addiction services for the county. Here, too, however, the public department is still covering basic protective services and routine foster care. All other cases are turned over to MPS, which develops and implements service, treatments, and placements through providers with whom it subcontracts. The contract also calls for MPS to develop an ambitious MIS, a field in which MPS has recognized expertise. However, although MPS has a case management function for cases referred to it, the Hamilton County Department, building on earlier negative experience, keeps ultimate case management within the department and ties into it the work of several "troubleshooting" senior staff members.

Colorado plans by the year 2000 to move from its current pilot experiments to a pattern under which counties will have the option of adopting or forgoing managed care and of deciding whether the county will serve as the MCO or elect to join other counties or privatize the MCO role, too.

Law (can the public subcontract its responsibility to protect children?), assessment of delivery system logic, and judgments as to its administration capacity and potential may all eventually be relevant to a state's decisions. These issues must all be settled in any given public jurisdiction (if only for an exploratory period) before contracting may begin.

Although it could eventually be determined in the courts that the responsible public agency must retain child protection responsibilities and thus cannot delegate full MCO prerogatives to a private entity, this remains an area of divided opinion so further experience would be useful. We would not wish to discourage one or two large jurisdictions (counties, big cities, states?) that wished to experiment with a private MCO structure. The issue of contracting for service with for-profit administrative service organizations (ACOs), which might develop or operate an MIS, is another matter. Here, as we suggested below, the question

of substantive expertise or access to expertise with regard to the service system becomes primary.

6. Management Information System

Targeted reform, efficient delivery systems, performance, or outcome-based contracting will require information, an undisputed and frequently repeated truism. Yet the country as a whole and the individual states have never been adequately equipped. A new federally funded system is now coming online almost everywhere and could provide the needed platform for an MIS designed to service the state's reform plans. This is a major cost item and requires careful thought.

Although it may constitute a brief detour, it may be useful to quote from a report that we published in 1989:

A fully satisfactory, systematic picture of child and family social services in the U.S. or of children in this system is impossible given the current status of terminology and data. There are not national data regarding the supply of services, the interventions used, or the characteristics of providers; nor are there data on the characteristics and numbers of children in each part of the system. Foster care data cannot be interrelated with child abuse/neglect reporting systems. Court statistics are something apart. The federal government dismantled its child welfare statistical activities in the 1970s, tried to get by with modest funding of a voluntary (and thus very incomplete) data system for child welfare in the 1980s, and now following a Congressional mandate enacted in 1986, is gearing up to reestablish a statistical system by 1991.

Moreover, whether for statistical or for program analysis, there is not consistent language used to describe the components of the system, let alone the specific services and interventions. Thus, for example, "child welfare" includes child protective services in some locales, but is a distinct and separate service category in others. "Ongoing services" is sometimes defined as meaning the supervisory/monitoring services provided to families that the courts have found abusive/neglectful and when the child is permitted to remain at home; and sometimes as the service provided families awaiting a court hearing. Intensive, home-based services are sometimes described as a preventive service, sometimes as a protective service and sometimes as a treatment service. And the distinction between prevention and protective services often seems irrelevant or at best confused.

A "child awaiting adoption" may be one for whom the home study has actually been completed, or one who parents' rights have been terminated but no adoption process even begun. Finally, the definition of a "case" varies. Sometimes a case is a child; and as many children as there are in a family, where there are allegations of abuse/neglect, each child has a separate case. In other locales, a case is an entire family.[1]

The choice of 1991 seemed realistic to Congress for a target date for a statistical system, after endless complications, changes, and political conflicts with regard to regulations for an earlier 1980 mandate and an administration that wanted to downsize federal social programs. It took 1993 legislation (part of a series of efforts) to settle rules for the Adoption and Foster Care Analysis and Reporting System (AFCARS) and for a State Automated Child Welfare Information System (SACWIS). Finally, by mid-1997 it could be said that 35 states were implementing SACWIS, and nine more were planning. AFCARS was producing the beginnings of a national picture. There was generous (75 percent) federal cost matching through 1997 and fair sharing (50 percent) thereafter. In addition to meeting minimum requirements for state reporting to Washington and claiming reimbursement, these systems may be elaborated at state initiative to meet many of the needs for planning, estimating, computing risks, case managing, outcome reporting, and all else in a state POS or managed care plan.

The topic of personnel should be raised in the policy–planning group that is laying out the basic framework.

Which brings us to the point of the discussion: The state planning process that develops the framework for the new initiatives will need a sector for attention to information and statistical control requirements. This is an area of specialized expertise, and the assigned planners should include those at work on the state system and those who will need to use the data. If the state staff does not include expertise at the cutting edge, it would be wise to employ outside consultants. Several private companies and nonprofit centers have established reputations in this field. The consultant selection process needs to be a careful one; a number of states have had frustrating and very costly experiences with consultants firms that underestimated the complexity of the task and did not adequately understand the

professional issues and the delivery system. Moreover, by now it would be desirable to coordinate this MIS with the one handling state Medicaid, Temporary Assistance to Needy Families, and other "welfare" programs.

As the process of plan implementation begins, it will be necessary to designate the agency that will prepare the specifications, receive the bids, make choices, negotiate contracts, and launch the new system. It would be helpful if this could be the organization that will administer the contracts with the MCOs, ACOs, providers, and others—all in the interest of a smooth transition. In any case, this, too, is an explicit decision to be assigned to the planners.

7. Prospects for Staffing?

It may seem strange to find this topic—staffing—listed along with the parameter-setting decisions that the contracting jurisdictions must make before they can issue RFPs. We introduce the topic at this early point because of what we observed in our explorations.

One jurisdiction learned that the MCO with which it had contracted to upgrade operations had to hire far too many "recycled, burned out child protection workers" (not our term) to achieve the upgrading sought. In another jurisdiction, it was said that when operations were under way and the agencies experienced problems, there were just not enough social workers available to staff an expanded operation. The schools began to gear up and one began a new program—but it would take time. The professional social work organization said that there were enough social workers in the state but that the reform plan was poorly conceived and offered few attractions. By contrast, another jurisdiction, also requiring a staff increase for "the new program," knew from experience that its salaries were competitive and its milieu attractive to out-of-staters. It went ahead with a national recruitment drive and had no problem on this score.

All of this suggests that the topic of personnel should be raised in the policy–planning group that is laying out the basic framework. It could affect the nature and scale of the reform, the timetable, the choice of a MCO, and (eventually) the specifics of the delivery system. The process may call for consultation with or surveys of current personnel (how many would plan to move to a new entity?); discussions and cooperative activity with professional schools, staff associations,

and unions; and plans with civil service organizations and authorities. The key issues will be how to ensure sufficient personnel with suitable qualifications for the new thrusts, whether in provider agencies, the MCO, or the contracting public department, and how to plan a personnel strategy that includes in contract provisions, as appropriate and where essential to the "scope of work," parent aides and paraprofessionals, several levels of child care staff, parent educators, youth workers, clinical psychologists, as well as child welfare social work staff.

We have introduced some thinking and experience with regard to the state's first decisions as it launches plans for a major child welfare reform:

- locating the planning process within the state
- looking at the diversity of "stakeholders"
- formulating a statement of mission or a "vision"
- deciding on the degree of (further) privatization
- choosing an overall strategy based in POS or managed care (or located between them)
- deciding whether (and how) to create integrated service networks
- deciding on a public or private MCO
- planning for the necessary MIS
- developing a personnel recruitment or training strategy.

Inevitably, for lack of well-documented and evaluated experiences, there will be many uncertainties. Where feasible, a developmental strategy would be wise: gradual phase-in, pauses to plan next steps, self-protective risk corridors, and ongoing task forces. We shall illustrate further.

Next, we turn to the specifics of developing an RFP process and selecting contractors, whether as MCOs, ACOs, or (mostly) as provider agencies.

Notes

[1] Annie B. Drissel and Cindy Brach, *Managed Care and Children and Family Services: A Guide for State and Local Officials* (Baltimore: Annie E. Casey Foundation, 1998), Part II, "Establish a managed care planning process."

[2] *Final Report from Treatment Component of Child Welfare Service Work Group* (Des Moines: IA: General Assembly, Feb. 2, 1998), p. 3.

[3] Sheila B. Kamerman and Alfred J. Kahn, *Social Services for Children, Youth and Families in the United States* (Greenwich, CT: The Annie E. Casey Foundation, 1998), pp. 29–30. Reprinted in special issue of *Child and Youth Services Review*, Vol. 12, Nos. 1/2 (1990).

From RFP to Contract: The Contracting Agency

4

With the framework decisions made and a perspective on staffing, the designated authorities in the state or county department (or another designated unit) are prepared to move forward. The first suggestion offered is *allow enough time.* Our informants are unanimous in describing excessive time pressures in their own experience. The contracting agency, in its eagerness to move forward, often underestimates what it takes to accomplish each of the tasks discussed below. Nor do they accurately assess how long it will take providers, following contract signing, to be up and running. What is enough time? Unfortunately, we cannot say. The steps need to be specified and estimates made in relation to the specifics of the jurisdiction. But the advice is apparently sound: estimate carefully—and then add time—to allow enough time.

Our second suggestion is a repetition of a point developed in Chapter 3: *involve interested parties ("stakeholders").* Without such involvement there is no assurance of a sound design and attention to goals, roles, process, laws, the multiple "stakes" of various organizations and professions, and the concerns of likely clients/consumers/patients.

Third, *be realistic and do not simplify.* It is not wise to award contracts to organizations that cannot deliver. They should not want to take on things they cannot manage and that could lead to serious financial loss.

Finally, to protect both contracting agency and potential providers and to allay anxiety, the request for proposal (RFP) should include reference to contract provisions for dispute resolution, appeals, and terminations.

1. Clarifying the Delivery System to Be Created

The starting point here is the goal—the "vision." The clarification can perhaps be seen as continuous with the pre-planning formulation called for in Chapter 3. The activity is central: Given the problems to be solved, how is this changed or enhanced, how is the redefined system conceptualized, and what operating units will it require to implement?

A working group, whether in house or more broadly representative, will need some months for this process if the intended reform is ambitious. If the working group is not broadly representative, its thinking should be exposed to critiques with a request for information (RFI) (see below).

In our review of jurisdictions that have undertaken new initiatives or are considering doing so, we note the varied concepts of their scope, a function of state departmental organization, coordination arrangements, and concepts of "child welfare" and "child mental health." The latter can mean anything from psychiatric interventions to individualized social casework. Obviously the process cannot move forward without clarification and specification, because it has important implications for funding, staff requirements, scope of services, and capacities of the providers to be involved (eligibility for Medicaid reimbursement, suitable professional accreditation). It may be useful to have consultation from the federal or state government; other jurisdictions; and private consultants specializing in child and family social services delivery, mental health, substance abuse, or managed care.

What follow are the major elements in a well-functioning delivery system.

- *Access.* What characterizes the target populations? How will cases enter the system? (case finding, reporting, referral, advocacy screening, and other arrangements)

- *Case Assessments.* What are the decisions as to what to do next with an abuse or neglect allegation and the longer-range "treatment?" (out-of-home placement, helping, and other choices)

- *Providers Needed.* What are the services, facilities, and programs that will be needed for this population—as judged from study of case samples, previous experience, current federal and state policy, and professional thinking about "best practice?" (family preservation, foster homes, congregate care facilities, group homes, family support services, parenting programs, independent living, adoption agencies)

- *Case Management System.* What provision will be made to ensure meshing services around the family or even within the individual case—to implement a family focus, holistic perspective, and accountability philosophy that keeps a situation in a community's field of vision until a deliberate decision is made

that such provision is not necessary? This is a major community service delivery design component and a managed care requirement.

- *Service Integration, Monitoring, and Technical Assistance.* If the commitment is to a "seamless system of service," who will observe the integration of services and have the recognized responsibility to identify and deal with problems and gaps, including the offer of technical assistance? Can this function be integrated with utilization reviews—assurances that the agencies and systems are operating as intended and meeting their responsibilities?

- *Reporting and Evaluation.* See Chapter 3 about management information systems (MISs). There are major information gaps in child welfare administration. Information systems often lack performance and child/family outcome data.

2. Clarifying Responsibilities to Be Retained by the Public Department

The state or county is not ready for an RFP until it clarifies which part of the delivery system will remain within the public department and which will be contracted out. As discussed in Chapter 3, thus far, almost all public departments have chosen to serve as managed care organizations (MCOs) after contracting, and there is some opinion that this is essential in child welfare. Many continue with the child protective function; some retain "simple" foster care and contract for what has variously been called "therapeutic foster care," "deep-end" cases, or all of "family preservation" (defined in Los Angeles County as covering children who could be in foster care but who are being served in the community). Hamilton County, Ohio, refers to Magellan, the MCO, all cases requiring specific treatment—services—intervention beyond the basics, and the public staff retains the case management role. Kansas refers cases to providers for family preservation, adoption, and foster care but also retains the protective services, case management, service monitoring, and technical assistance roles. Will the public department create and operate the MIS, or will that function be contracted out?

3. Estimating How Much and How Many

Before this listing can be translated into an action strategy or, more specifically, into one or more RFPs, the planners will need some numbers. Potential bidders

must also have such numbers to offer specific plans. Depending on how drastic the departure and how advanced or limited the existing MIS, this can be a large, time-consuming task. It will be essential to judge whether the case flow will increase or decrease either because of expected demographic or social problems shifts or because the new program and policies will create changes. Experienced public information systems staff will know how to make actuarial predictions and/or to run scenarios for the new delivery structure. But leaders of the planning process in the public and private sectors will need to be prepared to help develop the assumption to be built into the calculations if they are to be useful. At the minimum, they must assemble for their own and bidders' use a full statistical record of relevant prior experience.

The RFP should specify, especially for the benefit of providers previously funded under a former system, any changed funding plans and requirements, such as eligibility for Medicaid reimbursement.

4. Testing the Delivery Design

Ideally, there will be pilots or demonstrations. Absent time and opportunity, available experience suggests that those who design the delivery system need broad involvement of experienced people and relevant action to ensure acceptance and to avoid unnecessary errors. We have talked in Chapter 3 about the urgency of involving interested parties in the parameter-setting decisions. Depending on circumstances, the same mechanism could be used to get feedback with regard to the proposed delivery system design. But if that mechanism is not appropriate or available, the situation may call for an RFI. In brief, this is a statement of the philosophy, objectives, and delivery design for the proposed system and a statement of what the RFP will propose. Potential providers–bidders are asked to comment. The contracting group may follow up with questions. Where called for, a group of potential bidders could be convened for discussion of some issues. If the responses are carefully considered by the planners, they may strengthen the RFP.

We do not here review the content for an RFI because it may be conceived as a "preliminary draft for comment" of an RFP or of a segment of an RFP such as the "scope of work."

5. Drafting the Request for Proposal

This is a task for several working groups within the responsible administrative agency, augmented by specialists from the service systems as needed. Typically, a working group will include several managers and supervisors or senior practitioners. They must be people who understand the statutory base, federal policy requirements, financing and billing–auditing procedures, reporting and other accountability mechanisms, best practices in the field at issue and all else deemed essential to the agency's mission and the place of the sections of the RFP to which they are assigned.

Each working group will need to have—as supplied by the director or coordinator of the RFP-writing project—an outline and ground rules. The chair of each group, preferably a senior manager, should have ready access to the director–coordinator to clarify issues as the work moves forward. The director should continuously monitor progress and pace and serve as a general facilitator and coordinator. A constant flow of "minutes" will aid the coordination task and provide raw material for the working group's contributions to the final RFP. This will require assignment of a "recorder" within each working group and an eventual editor–drafter for the RFP. The chairs of the working groups and the director might then serve as the reviewers of successive drafts until there is a recommended RFP. If the department's secretary–director–commissioner is not part of this process, he or she or they should review the draft before it is finalized.

6. Determining the Scope of the Request for Proposal for Provider Agencies

Borrowing from several jurisdictions, we offer in what follows several listings of RFP topics, again noting, as we did in Chapter 2, that our intent is illustrative only and that, for lack of outcome data as of this time, we can say only that these jurisdictions successfully contracted and are under way. The RFPs have "face" validity. Readers will note their varied styles and preoccupations—which seems to be what one should expect given variations of many kinds among the jurisdictions.

Figure 1

Los Angeles County Community Family Preservation Network
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The L.A. illustrations are from Los Angeles, Department of Children's Services, Request for Proposals, Community Family Preservation (October 1998)

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Los Angeles' County's Request for Proposal for Lead Agencies to Create Community Networks for Family Preservation

In offering the RFP (see Figure 1 for outline of topics), the director of the Department of Children's Services, the chief probation officer, and the director of the Department of Mental Health defined the county objectives, which they had come together to advance. The 38,000 county children living in foster care in the county in 1994 represented a 100 percent increase since 1985. The three departments had joined in an effort to expand and strengthen family preservation activities to reduce child risk; increase children's safety in their own homes; and ensure children's welfare, broadly defined. The "partners," as they named themselves, were calling on members of the provider community to come forward as lead agencies which, in turn, would subcontract with other local agencies to ensure "that the full range of essential services are available" to these families and that priority access for these families is negotiated with other publicly funded programs (child care, health care, housing, income support, physical and developmental services, special education, substance abuse treatment). The contracts would be for direct services and related coordination, accountability, and management.

In relatively few pages, mission and philosophy are clearly framed. Providers and their communities are asked to join in the effort. A full calendar schedule is offered covering dates from submission of questions, a proposers' conference, submission of letters of intent, written answers to questions, deadlines for proposals, site visits, recommendations to the Board of Supervisors and their action, and the project starting date.

The table of contents is presented in Figure 1 to specify some of the work to be done within the applicant agency and the need for time. We highlight the "Statement of Work" and the "Task and Deliverables," which combine required service activity with the administration, monitoring and evaluation functions, and instructions and requirements for proposal submission.

A team in the children's services or probation departments conducts for each case an assessment for child risk and family functioning. When the case comes to the lead agency it comes with a classification into Level I, II, or III, each of which carries a monthly payment rate, based on an "average mix of services" at that risk

level. (Tennessee is another of a number of jurisdictions creating "blended rates out of averages.") The lead agency pays subcontractors for their services. The county pays for certain auxiliary services outside the community network. "Family preservation" is defined as a time-limited (almost always one-year) and intensive intervention. The RFP summarizes the expected services and the predicted course of each based on prior experience. The specific time limits for service are set, with some provisions to propose extension. The payments are prospective—so each party is at risk. If the provider continues beyond the time or, if the case returns, the burden is theirs. On the other hand, the public agency may be paying for cases for which less is required.

A Kansas Request for Proposal, With Major Elements of Managed Care

We offer as another illustration of scope the Kansas RFP for foster care. As widely noted, there have been some implementation problems variously attributed to several factors, but this does not diminish the RFP outline and allows for comment on some of the steps.

The Kansas RFP lacks a table of contents, which we might duplicate, but we have made our own—varying the amount of subheading detail. Although the RFP is covered in 36 pages, 14 attachments and a very long section of written questions from potential bidders and the agency responses serve to illustrate other approaches to informing and aiding the services community.

Before the 14-page "statement of work," the RFP concentrates on the contracting, procedural, and administrative business. At the top of the proposal, the responding agency is shown that it must set its price per child per referral for year 1, 2, 3, and 4 and indicate the regions for which it is bidding (region 1, 2, 3, 4, or 5). After assessments and screening, the final evaluation and awards are to be made by a Negotiations Procurement Committee or its designees. The committee consists of the secretary of the Department of Administration; the director of Purchases of the Department of Administration; and the secretary of Social and Rehabilitation Services, who has responsibility for the Commission for Child and Family Services. We have here an explicit statement that this is to be procurement by negotiation. Our review of various jurisdictions suggests that many will find this an essential process even if somewhat contrary to preferred principles of

"blind" evaluation, completely objective scoring, and business-principled contracting. The problem is that what the reforms are seeking cannot be ensured only by specifying a series of readily measured items on a scoring sheet and totaling those ratings. There are items to rate, but there also will or should be in the proposals new ideas and combinations that are clear only when the application is also looked at as a whole and in relation to others (and also as possibly forming a good combination with others) during a final review or during negotiations.

In short, RFP reviewers at the highest levels must remain mission-oriented planners, and jurisdictions (like New York City) with rigid, statutory rules and requirements governing RFP processing will need to provide maneuvering space to those public officials expected to convert agency bids into reformed service systems.

To return to the Kansas illustration: Before the statement of work, the RFP offers potential bidders rules and procedures for attending a prebid conference, requesting answers for questions, preparing and submitting a proposal, and it explains general contract terms. Technical provisions for the transmittal letter are specified, as are federal and state laws and a court decision that governs the work. Qualification for direct services staff are listed. A full section of the RFP on vendor qualification and experience is outlined and clarifies the way in which proposals will be scrutinized (see pp. 17–19 from Kansas Foster Care RFP in Figure 2).

The RFP has a tough stance on payment—which is a major change for the agencies to face: "This is a contract not a grant … The capitated rate is the total payment per child." The RFP spells out the basis for the department's computation of capitated rates and what costs are assumed to be included in the per child/family service costs. For example, the Supplemental Security Income child per diem serves as a maintenance rate. The payment schedules are specified for children already in placement and (as below) for new referrals:

- 25 percent of capitated rate at time of referral
- 25 percent on receipt of first 60 days' progress report (or on case closure, if sooner)
- 25 percent on receipt of 180-day formal case plan review (or on case closure, if sooner)

Figure 2

From Kansas City Foster Care RFP

4.5 Vendor Qualifications and Experience

a. A description of the vendor's qualifications and experience providing the requested or similar service including job descriptions of personnel assigned to the project stating their education and work experience shall be submitted. The vendor must be an established firm recognized for its capacity to perform. The vendor must be capable of mobilizing sufficient personnel to meet the deadlines specified in the Request. Proposals should include job descriptions for all professional management and direct service staff. These positions should be outlined on an organizational chart. Job descriptions are excluded from the proposal page limitations.

Each proposal submitted shall demonstrate the vendor's ability to design, develop, implement, and deliver Foster/Group Care Services to an identified SRS client population. It is expected that each proposal reflects the vendor's understanding of the issues of separation and attachment and a child's need for permanence. Vendors should clearly delineate their assumptions related to program design and implementation.

Acute care facilities, including free-standing psychiatric facilities, must be JCAHO approved and must be enrolled as a Medicaid provider, or be eligible to enroll by virtue of this contract. Acute care facilities are deemed eligible to enroll as a Medicaid provider if granted this contract or as a subcontractor.

b. Each proposal shall contain:

1. A description of the proposed service delivery model.
2. An implementation plan with the targeted start date of February 1, 1997. Describe the steps to be taken to ensure that implementation will begin on schedule by including appropriate timelines.
3. Strategies for meeting all the requirements and expectations as identified in this RFP.
4. A signed transmittal letter with all required statements and assurances, and an appendix and of no more than twelve pages, of comprehensive continuum of services, job descriptions, and chief executive and staff credentials.
5. A separate program budget and budget narrative of no more than three pages shall be submitted delineating estimated start-up costs. (Attach to separate fiscal bid.)
6. Annual projected costs for four years. (Attach to separate fiscal bid.)
7. A fiscal statement demonstrating the agency has the fiscal capability to maintain services until revenues are received for the duration of the contract. (Attach to fiscal bid.)
8. A plan for achieving or maintaining accreditation.

c. Each proposal shall demonstrate:

1. **Philosophy:** Describe the vendor's vision, mission, and underlying values as related to: (a) foster/group care placement; (b) services to child in out-of-home placement; (c) reintegration services for families/permanency for children; (d) treatment services; (e) recruitment and preparation/assessment of foster families; (f) Independent Living Services; and (g) other privatization initiatives.
2. **Organizational Structure:** The vendor must demonstrate an administrative and organizational structure which supports a high-quality, comprehensive program. Vendor shall discuss how the organizational structure will facilitate the delivery of services.
3. **Client/Service Issues:** The vendor has considerable latitude in designing a service delivery program and the scope of services. The program design should contain: (a) a plan for a centralized point of referral; (b) a plan for provision of emergency placement services; (c) a plan for initiating dual case planning; (d) a description of methodology used to select the appropriate group care or family foster home placement; (e) a plan for managing the case especially in regard to placements and replacements with

subcontractors; (f) a plan to provide a comprehensive continuum of services to meet the placement and treatment needs of the child (see Attachment A for outline to describe each proposed type of service); (g) a plan for comprehensive reintegration services to families/permanency services for children; (h) a plan for meeting the specific needs for children who require specialization programs, i.e., drug and alcohol services, maternity care, hospitalization, etc.; (i) a plan to provide independent living services for eligible youth 16 and over; (j) a plan for exploring relatives as placement resources (Family and Relatives are used inter-changeably. For definition of relative, see KSA 38-1502(p)); (k) a plan for follow-up services after reintegration/independence has occurred; and (l) a plan to meet all assurances set forth in this RFP.

4. **Coordination:** Effective coordination with SRS and other service delivery systems is essential in the management of a foster/group care program. (a) Identify information needed from SRS to successfully manage the program and work with children and families. (b) Describe a plan for coordination among the contractor, SRS, courts, and other privatization contractors. (c) Describe a plan for active involvement with school systems, especially upon the child entering and leaving said school system. (d) Describe a plan for assuring child receives regular medical care. (e) Present a conceptualized plan for coordinating services to the child and the family preservation contractor and/or the adoption contractor at the time the child's goal changes to adoption. (f) Describe how the contractor will sub-contract with other agencies. (g) Describe a plan for serving children residing outside the region at time of implementation. This must contain letters of commitment from subcontractors and collaborators.

5. **Program Development:** (a) Describe how the vendor will assure coverage in all geographic areas of the region(s). (b) Describe how the contractor will promote and develop services in all areas of the region. (c) Describe a training plan to assure adequate staff development. (d) Describe a recruitment and initial training plan for foster parents. (e) Describe a plan for on-going training and support services for foster families. (f) Describe a plan for assessing relatives for placement.

6. **Service Delivery History:** Describe the contractor's prior and current experience in the delivery and administration of social service programs. Describe the scope of services. Describe the geographic area served.

Note: It is the belief of SRS that there are numerous, current providers across the state of Kansas who are quite qualified to provide out-of-home services. Based on this belief, it is the assumption of SRS that the contractor will capitalize on the utilization of existing programs when at all possible. Should the contractor's design illustrate that more than 50% of the deliverables are being provided directly by the contractor and not through existing locally based providers, please indicate clearly the rationale for such a decision.

- balance six months after child returns home or when permanency goal is achieved (the agency is responsible for out-of-state placement educational costs).

For the first year the shared risk (calculated from aggregate data) was at the marginal rate of 20 percent in either direction. The state would reimburse the provider for costs over 120 percent of the capitated rate. The provider would reimburse the department if its costs were below 80 percent. The risk-sharing rate was renegotiated for the second year. There is also risk associated with re-entry into care after reintegration with the family. The provider agency is responsible for services, including out-of-home services, to a family from the time the agency

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receives a case and its prospective fee and until the 12 months immediately following reintegration, without additional funding. Re-entry to foster care after 12 months is defined as a new referral and paid as such. This plan removes any incentive to hold onto a case and requires that potential bidders consider their ability to manage and do well with the capitated rate. We encountered two situations elsewhere in which the state or city plans had to be aborted for lack of adequate bids. The rates or risks could have been factors, but we are not certain. (Two of three Kansas lead agencies were outside their risk corridors in the first year, and adjustments followed.)

The statement of the scope of work is the heart of the RFP.

The statement of work is detailed and in a clear context. Coping with "increasingly complex client needs" and the requirements from the settlement of a court case brought by the American Civil Liberties Union, "the Department is looking to the private sector to share the service delivery challenge." The department offers data about numbers and average per case costs for various specific services under its "levels of care" system. It solicits proposals from the private sector, premised on a "no reject–no eject" philosophy, to design a "seamless" system of care for children and their families—reflecting current thinking about protection, family reintegration, and permanency. Required client pathways are specified and the department's ongoing responsibilities are delineated. Quantitative outcome criteria for children in the several categories are specified (see below).

A detailed series of appendix materials elaborates and documents all of the components to facilitate the provider agency's estimates and plans. A multipage segment (see below) reports questions raised about each section by potential bidders and provides the department's responses. This section is extremely helpful. Each of the other RFPs (adoption, family preservation) has a similar section. Extensive sections with quantitative data are responsive to the bidder's needs to enter these "risks" contracts with some confidence that potential caseloads, case costs, and caseload dynamics are known and that their decisions about the offer can be based in realities.

New York City's Request for Proposal for Bronx Child Welfare Services

Our third illustration of a provider RFP comes from New York City's Administration for Children's Services (ACS). It was issued on June 4, 1998, and proposals were due on August 12. The results of the selection were announced early in 1999. Earlier, the department had solicited comments on a full "scope of services" document on November 19, 1997, calling for comments by December 17. Again we note the need to schedule time for the process. Indeed, the first announcement of the reform goals behind the RFP had been made by the mayor in December 1996.

This RFP is part of the city's major child welfare reform process. The reform components, as announced, are neighborhood-based services, a continuum of care through service networks, and outcome measurement. With a several-year phase-in planned, the intent is to raise the outcome standards gradually. The program continues the city's purchase-of-service pattern without introducing risk-sharing, but there may be some experimentation with risks in the near future under a federal Title IV-E waiver to the state.

Most of New York City child welfare services, beyond protective investigation and case management, have long been privatized. With ACS remaining in the child protection, assessment, and case management roles, the changes sought in the RFP relate to the shift to a neighborhood base and to greater outcome accountability. Unlike Los Angeles, New York City does not call for lead agencies that will contract but invite potential providers to respond to any of the seven services being proffered, individually or in combination. However, an agency offering to undertake congregate care and foster care must also provide medical, mental health, and independent-living services for their clients. An agency may apply on its own but is encouraged to forge links with other child welfare providers that will serve the neighborhood and with service providers outside the child welfare system. The applicant must demonstrate the availability to their clients of all essential services. When applicants forge linkages, they must describe the governance pattern (referrals, care management organizations, subcontracts). (In fact, few comprehensive collaboratives in the Los Angeles sense were proposed. After the choices among the bidders, ACS itself undertook in most instances to create needed networks.)

For the provider agencies—and for observers—one of the large issues was/is how a new commitment to neighborhood-based services would impact on long-established, large, highly professional children's agencies and how the ACS would integrate the less-experienced, less-professionalized, somewhat less-traditional local community-based organizations (CBOs). The latter in a sense have the political advantage of strong support by the city's policy makers, while lacking in expertise and proven competencies. They represent a preferred decentralized resource and the likelihood of "cultural competence." The community district (CD) (a New York City designation) will be the unit of accountability for the neighborhood-based initiatives, but several CDs may be served by one provider, and smaller neighborhoods within a CD may be targeted by several providers. Here, too, it is the large, traditional agency with city-wide or borough outlets that faced complex choices in specifying the subareas of the Bronx for which it would bid. (It was not known when the Bronx RFP was issued when or in what units the RFPs for the rest of the city would be issued. In retrospect, a public authority that wanted optimum planning for efficient use of their capacities by the bidding agencies would have revealed the entire pattern at once. In this case, ACS, too, was in a learning mode.)

The RFP of June 6 called for vendors to provide one or more of the following services in the borough of the Bronx:

- foster boarding home care (including medical, mental health, and independent-living components)
- congregate care (including the same components as above)
- preventive services (in New York City this means services and treatment short of out-of-home placement—much like "family preservation" in Los Angeles)
- medical and mental health services
- homemaker services
- independent-living services.

These are all currently contracted services. The change is with regard to the delivery system. The RFP specifies the ACS objective:

Specifically, in part through this RFP, ACS will move towards a more closely integrated, neighborhood-based service system, where children and families receive the services they need in their own communities, when appropriate, through ACS-funded child welfare organizations as well as through extended networks of care. ACS believes that a neighborhood-based services system will improve safety for children through neighborhood networks dedicated to detecting abuse and neglect and will reduce the trauma of separation for children in care while increasing the possibility, timeliness, and quality of permanency for the child.

This shift to neighborhood-based services will be accompanied by other changes in each service area. One such change is the Family to Family service philosophy and approach to foster boarding home care. As a result of Family to Family, "communities of care" comprised of those individuals most central to and concerned about a child's well being (birth parent or caretaker, foster parent, and caseworker) should inform the child's service plan as much as possible. Similarly, congregate care programs should establish a relationship with the community the child may be residing in after discharge, if known, in order to ensure a successful and healthy transition to life outside of the foster care system. Preventive services should address both the individual needs of the child as well as the family members residing with the child in the context of the socio-economic realities which affect and impact their daily lives. The design and delivery of health services should be child focused and family friendly, and should lead to the creation of a "medical home" for each child entrusted to ACS's custody. Like other child welfare activities, independent living services should be neighborhood-based, whenever possible and appropriate. Finally, homemaker agencies should be linked to the communities of the families they serve through relationships with other ACS-funded preventive service and foster care agencies.[3]

The contracts resulting from the competitive solicitation will be for up to three years. All but homemaker service contracts will include two additional three-year renewal options if funds are available and obligations have been met. The homemaker contract provides for one additional three-year renewal option.

After the quoted statement of objectives in an introductory summary, the RFP then offers a preproposal conference, a proposal deadline, and the address and telephone number of the one authorized contact person. An applicant checklist follows.

The first 25 pages of the RFP review purpose; timetable; evaluation procedures; the proposal package; submission procedures; and general information of importance to bidders, including appeal rights, payment policy, and insurance requirements. Appendix materials complete the packet (not numbered in one sequence), which is many times 25 pages. Appendix A offers a specific application form and evaluation criteria for each of the seven services (in contrast to the Kansas pattern of a separate RFP for each of three services). The point rating scale is provided for each of the proposal components, and the scale item is in each instance explained (program design, 35 points; implementation plan, 5 points; bonus provision for creativity, 5 points; budget–costs–finances, 20 points; organizational capacity, 10 points; community readiness, meaning the agency's history of community engagement or its strategy for engaging the community, 10 points; past performance on contracts, 20 points; quality assurance and improvement, 5 points).

An appendix on the scope of services offers a rich and detailed statement for each of the seven services. This material is complete, sophisticated, and a virtual textbook. Another appendix acknowledges that the mounting of so complex an innovation and change process requires time. It suggests time periods for each component's implementation, usually 6 months to a year, but agencies whose circumstances require variations are invited to specify. A response template is included.

Another full appendix is devoted to budget templates and detailed instructions. A final appendix is a comprehensive statement of foster care standards, elaborating philosophy and operational plans for a neighborhood-based, community-oriented system committed to the "Family to Family" philosophy. Here, the ACS affirms its mission commitment, and the bidder can be clear about what is sought.

Finally, a list is provided of documents available to clarify various service issues and surrounding relevant demographic and service data.

At the time just before the announcement of choices among the bidders, the staff could summarize "learnings" from the Bronx RFP process which, presumably, will somewhat strengthen the "rest of the city" RFP to follow:

- It is urgent to set a page limit on the length of a submission, with margins, font size, and so forth specified. Processing had been slowed by many voluminous submissions.

- Given a mix of large, city-wide long established and highly expert and experienced professional agencies and many CBOs whose community roots and ethnic–social–cultural competencies are valuable for the design sought, it is not realistic to expect the latter to compete on professional expertise, and they probably require technical assistance in the process.

- Given the neighborhood–community district patterns and the inevitably incomplete coverage picture that will emerge when big and small agencies are selective in choice of areas that they offer to cover, the contracting agency must be active (whether in setting up the bidding rules or in processing them) so as to create neighborhood networks. In both these regards the process and procedures must conform to local law, which seeks to avoid corruption and favoritism in contract awards. (The Los Angeles department was less constrained in helping and guiding to ensure comprehensive networks as needed, with the desired neighborhood characteristics.)

- The pattern of bid rating by three-member internal teams, one a high-ranking management or substantive expert, worked well. However, inevitably, a mission orientation requires the top managers to have some discretion in putting the package together. We have seen this everywhere; state and local law and directives should take notice. Dedication to mission requires a level of experience and sensitivity that may be subverted by a pure market process in which everything is decided by pre-fixed scoring systems.

- How, once operations are under way, will ACS evaluate provider performance? They have plans to evaluate their performance by "triangulating" quantitative performance indicators, quantitative outcome indicators, and qualitative agency operational indicators. Thus, their philosophy is conveyed.

Without pursuing detail, some of the range in public department approaches may be further suggested by Tennessee. A "Strategic Plan for Improving Services for Tennessee's Children" conveys vision, mission, quantitative, and qualitative objectives. (A few brief illustrations follow.) A "Provider Policy Manual" offers great detail on the scope of work, describing all services for Phase I (continua of care for children in state custody) and Phase II (community-based service

networks for children not in custody). With such background, agencies are well briefed as they consider the particular RFPs.

7. An RFP for a Management Services Organization Covering a Portion of the Department's Responsibilities

The Los Angeles and Kansas illustrations involve a public agency that retains certain central functions and that contracts with providers for treatment, education, and placement services. But some limited number of public authorities to date are contracting for administrative functions (an MIS, for example) or for an organization to undertake a major management services organization (MSO) task. Hamilton County, Ohio, it will be recalled, did just that with a "for profit," Magellan Public Solutions (MPS) to create and operate an MSO to contract with service providers and to case manage child welfare, mental health, and addiction services and also to create a related MIS and operate it. Here, too, however, the county remains responsible for initial access, protective services, and foster care but, unlike our previous two illustrations where the public department turned cases over to a specific provider for a specific services package (Levels I, II, and III family preservation in Los Angeles; foster care, family preservation, or adoption in Kansas), in Hamilton County the contractor must determine the specifics of the service required by the case assessment and to choose the provider from among those with whom it has contracted.

Attention to the Hamilton County RFP introduces some new elements related to a somewhat broader contract mandate and to the for-profit contractor. The 1996 RFP to which we will refer called for submissions by November 15, 1996. The contract was signed on August 27, 1997, and operation began in January 1998 (note the time). Faced by a child welfare financing crisis and an inability to meet the terms of a court consent decree, officials felt that it was essential to end what they perceived as provider incentives to keep foster care beds filled and to substitute financial incentives to avoid or shorten placements. This would also require good case-by-case information (e.g., a new MIS). All of this helped shape the RFP, which was presented in three bound documents totaling about 150 (mostly unnumbered) pages. Volume I is the core of the RFP; Volume II has four appendices, and Volume III is the appendix relevant to the MIS.

The table of contents for Volume I is far less detailed than the one for Los Angeles. We annotate as necessary:

Overview: Here we reproduce, following this page (Figure 3), the statement of objectives, mission, policies and constraints, relationship of MSOs to service providers, and funds available.[1]

(a) Roles of the Three Partner Agencies. Human Services, Mental Health Board, Alcohol and Drug Addiction Services Board.

(b) Descriptions of the Partner Agencies' Responsibilities and Programs.

(c) The Roles for the DHS and MSO Caseworkers. "The Partnership Team's intention is to contract with an MSO to administer, arrange, and develop a network of providers to deliver a full range of MH&A (mental health and alcohol and other drug addiction services) for children and their families presently under DHS responsibility and other Hamilton County citizens." Thus *"in many ways the role of the DHS caseworker will remain the same"* (emphasis supplied), because the MH&A services "are only one area of services delivery." Resources will come from private insurance, Medicaid, DHS, and the Alcohol and Drug Addiction Services. (Here we comment that as developed in the contract and implementation, the definition of mental health is broad, covering all services beyond the basic protective investigation, uncomplicated foster care, and case management. A chart emphasizes the DHS caseworker oversight of the MSO casework, however.

(d) Scope of Work. Here, as elsewhere, the statement of the scope of work is the heart of the RFP. Again it serves to document the importance of careful planning in regard to roles, a clear conception of a delivery system, a strategy in regard to oversight and accountability, and a judgment as to bidder capabilities.

Figure 3

MISSION STATEMENTS

Department of Human Services

We, the staff of the Hamilton County Department of Human Services, are committed to extending a lifeline to those in need. We seek to enhance the quality of life and foster independence through publicly funded social, financial, and support services. We do this with respect for each other and those we serve in a climate which promotes professionalism and values diversity.

Alcohol and Drug Addiction Services Board

The Alcohol and Drug Addiction Services System (ADAS System) will be the area's primary means of planning, delivering, managing, measuring, and evaluating a continuum of services to ensure alcohol and drug addictions are prevented and/or minimized among individuals, families, groups, and the community at large. The purpose of the ADAS System is to provide treatment, education, prevention services that are effective, cost-efficient, and accessible to reduce the incidence of alcohol and drug addiction in our area. ADAS System assists alcohol- or chemical dependent individuals to become functional citizens through a partnership in service delivery and management for treatment, education, and prevention, in order to achieve measurable results that can be sustained over time. This partnership is a relationship with providers, managers, and consumers of care, to benefit the community at large.

Community Mental Health Board

We, the staff of the Hamilton County Community Mental Health Board, are committed to the use of vision, strategy, and planning to assure that a system of high quality, cost effective, culturally sensitive, and responsive services and related community supports are available and accessible to all persons in the community who need such services. The Board will also work proactively toward eliminating the stigma associated with mental illness, and to promote an understanding of mental illness as a treatable, manageable disease.

Henceforth in this document, Hamilton County's Alcohol and Drug Addiction Services Board, Community Mental Health Board, and Department of Human Services shall be known as the Partnership Team.

I. Overview

A. Purpose of Request for Proposal

The Hamilton County Alcohol and Drug Addiction Services Board (ADAS), the Hamilton County Community Mental Health Board (MHB), and the Hamilton County Department of Human Services (DHS), henceforth the Partnership Team, wish to contract the services of a Management Services Organization (MSO). The purposes are to:

- ensure a seamless managed care system of child welfare, mental health, and alcohol and other drug addiction (MH&A) services for Hamilton County consumers served by DHS, ADA and MHB;
- prepare independent MH&A and child welfare providers for a managed care environment;
- assist MH&A providers to become the "providers of choice" in both public and private sector markets via this MSO; and
- reduce total costs to the Partnership and community by realizing economies of scale through one administrative/management services organization.

The MSO will develop and administer a computer-based management information system for service providers. (Please refer to the figure on the following page.)

The initial contract term reflects required preparation in moving providers and funding agencies toward at-risk capitation. The Partnership Team believes that blending state-of-the-art management information system technology with human services, public social welfare, and clinical services of MH&A providers will greatly enhance program and financial performance.

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The Partnership Team and present providers are not prepared to enter into at-risk, capitated, managed care agreements. The transformation from fee-for-service to capitation will occur over a reasonable period of time (not to exceed 18 months) through phased implementation as the MSO and providers demonstrate the ability to manage risk. When capitation is implemented, specifics regarding profit, risk pools, and cost savings will be negotiated.

B. Organizational Structure and Creativity

1. Bidder and Selected MSO Vendor

The successful MSO bidder may be an individual or a company. The MSO bidder must demonstrate that it meets the full requirements of this RFP, either within its own organizational resources or by one or more subcontracts. Should the bidder be unable to deliver all administrative services within its own organization, it shall demonstrate the capacity of its entire team including all named subcontractors. In particular, as a bidder responds to the questions in Section VII, the proposal must clearly specify the actual service provider and their experience.

The evaluation process shall include an evaluation of all subcontractors as if they were part of the prime contracting bidder. Therefore, complete information on subcontractors is required. In order to qualify, we require that each bidder establish their complete team prior to proposal submission.

2. Hamilton County Consideration

The bidder is asked to develop an organizational structure which will ensure adequate input from the service providers, customers for MSO services, funding agencies, outside business entities, and community interests (particularly clients served by these funds). The Partnership Team requires that the bidder's proposed organizational structure meet the following parameters:

- Local Community Control—Perhaps the most important consideration is that the control of local services to Hamilton County citizens remain local. We require that the new MSO entity be fully responsive to those local concerns.
- Service Provider and Customer Input—Service providers will become MSO customers if, and only if, the MSO is responsive to their needs. For example, if volume allows the cost per transaction to be reduced, more service providers will become customers of MSO services. The bidder must plan services for current service providers, and must be prepared to successfully market MSO services to additional providers inside and outside of Hamilton County.
- Policy Coordination—The Partnership Team is vitally interested in the successful bidder's profitability in this project. Profitability will stimulate new, innovative, and cost-effective systems for service providers and funding agencies. As the MSO expands/increases its management services to additional agencies and for a broader array of services, profitability to the bidder should increase, and initial service providers/customers should see reduced operating costs.
- Local Manager and Public Relations—It will be essential for MSO growth the have local Cincinnati management that demonstrates knowledge of the local environment and local service delivery. There are several individuals within the funding agencies who could be management candidates.
- Local Contracting of Client Services—It may be preferable to have provider contracts for services be executed with a local corporation, rather than a national corporation. The local organization would be operated within Ohio law.
- Advocacy of Local Service Providers—Both public and private local service providers are ill equipped to compete in the managed care environment. Most state, county, and federal programs are moving toward some type of risk sharing by providers. However, neither the providers nor the funding agencies are prepared to accept these risks. The MSO must aggressively assist both the providers and funding agencies to become ready to meet the needs and demands of managed care.

continued

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- Local Community Public Interest—The successful MSO bidder must contractually agree no to be or become (a) a service provider, or (b) a competing third party payor, insurer, network manager, HMO or the like, in the greater Cincinnati area for behavioral health and addiction services.

3. Creativity, Financial Arrangements and Contracts Term

The Partnership Team is seeking a long-term relationship with the successful bidder. This RFP and the eventual contract contemplates an initial term of five (5) years. The Partnership Team will entertain other contract term lengths, particularly if based on a need to spread costs or lower monthly direct costs. This is an area where creativity needs to be applied, particularly in light of costing the proposal.

The Partnership Team is soliciting proposals from bidders that can design a creative financing arrangement (capital and operating), and who can see the profitable advantage of a long term relationship with funding and provider agencies.

The Partnership Team envisions a successful bidder presenting a proposal that contains no "up front" costs to the funding agencies. Rather, the Partnership Team envisions (i) an investment by the bidder to cover the front-end development and capital costs, and (ii) a financial return on that bidder's investment over the contract term through operation of the MSO services to service providers and funding agencies.

Legal counsel will necessarily be required to review any organizational model in terms of present ORC and other possible legal constraints, and to develop corporate documents, e.g., articles of incorporations, operating agreements, by-laws.

This RFP outlines requirements for the overall Hamilton County system—it requires a creative approach. There are few companies today that are already providing the range of management services that we require. Therefore, the Partnership Team is looking for the bidder that will think "outside the box," outside the traditional pattern, and yet has significant experience in, for instance, information systems at the service provider and management levels, and management of child welfare and MH&A services.

C. Relationships with service providers

The Partnership Team will contract (jointly or separately) with an MSO to manage and develop a network of providers through whom they will fund the purchase of outpatient and therapeutic residential MH&A services provided by the Children's Services Division of DHS and by ADAS for distinct but sometimes overlapping groups of consumers. The contract will encompass a number of MH&A services currently purchased by DHS and ADAS estimated at $40,000,000 in 1996. Table 1 below depicts Medicaid reimbursements currently being captured by the Partnership Team members or their providers.

Table 1: Budgeted 1996 Service Dollars for ADAS and DHS

Team Member	Medicaid Reimbursements	Real Dollars	Grand Totals
ADAS	$1.10 Million	$10.7 Million	$11.80 Million
DHS	$0.85 Million*	$17.0 Million	$17.85 Million
Totals	$1.95 Million	$27.7 Million	$29.65 Million

*This figure does not reflect any of the Medicaid reimbursement requests currently being processed by Family and Children First Management (FCF Management).

Pages from Volume I of Hamilton, Ohio, RFP (1996).

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We list the new subcategories covered:

- *General Overview.* The MSO is to take responsibility for major administrative and planning tasks and for the development of major instruments for oversight and accountability. Here the outsider asks whether the contracting partners are not risking their mission unless they find a contractee with professional competence superior to theirs or at least not inferior. The contracting dilemma will be that the answer will differ by the type of competence. Involved are: service protocols; utilization review processes; standardized guides to gate-keeping decisions; a data collection system; provider contracts; credentialing standards and processes; outcome criteria; standards to be applied to provider agencies; data collection for program, service, fiscal, and overall outcome evaluation, client tracking, and case coordination; automated system for records–billing–tracking, and quality management. In addition, the MSO is expected to assist in the development, implementation, and maintenance of a mental health care service continuum provider network. (The department processed the provider RFPs and turned the entire roster of acceptable agencies over to the MPS, which made choices and negotiated contracts.)

- *Provider Panel Service Continuum.* The continuum lists 13 "outpatient mental health services" and "therapeutic out-of-home placements." Many of these are in some perspectives in the traditional social work child welfare repertoire, but for which Medicaid mental health funding has been sought in many jurisdictions.

- *Computer-Based Information System.* The system is a major objective of the RFP. The MIS to be developed is to involve data and reports on the individual provider (agency level and the management oversight level). Two charts specify the required modules and their applications, dealing with the overall MIS system capabilities and specifying which are to apply to every service provider.

- *MSO Responsibilities.* This is the largest section of the RFP. (see first paragraph on page 88). An interesting distinction is introduced between those responsibilities initially purchased from the MSO and those initially deferred by DHS but potentially available for contracting. In short, hope is implied of a successful and growing relationship—something we assume that would be attractive

to a for-profit bidder. Considerable detail is offered as to the MSO's creation of a provider network and its training–administrative–referral–coordination–oversight–evaluation functions. There is considerable specificity as to required data and reports from the MIS.

- *Anticipated Time Frames.* The schedule allows only slightly more than a month from RFP release to submission deadline and then six weeks to expected date of contract selection. Obviously, the planned RFP release was no surprise, and bidders were allowed time to prepare. Three months after contracting, the service delivery system was to be operational, as was the MIS. In actual fact, operation began a bit over a year after the selection. The contract was signed eight months after the date specified for proposal selection. Informants stressed the time requirements of the process: 15 months to prepare the RFP, three months to review major bids, adequate time for the contract winner to prepare to implement (including selection of providers and contracting), and adequate time to train DHS and MSO staff to work together in new roles.

- *An Outline for Proposal Content.* A five-page outline that specifies that responses about program will be "worth" 25 percent of the total evaluation score; responses on the MIS and administration issues, 50 percent; and responses on fiscal matters, the remaining 25 percent. This outline asks for the materials and responses essential to this scoring.

- *Evaluation Process.* How the review of proposals will be conducted. Two preliminary screening and assessment stages will be "blind," but the final stage will not be because it will be necessary to analyze the bidders' operational capabilities.

- *Instructions for Proposal Submission.*

- *General Requirements.* Beyond various caveats and administrative matters, this section specifies that data collected and reported as part of the program, including all data elements in the MIS, shall be the property of the Partnership Team. On request or termination, data and files shall be turned over to the team. As finally specified in the contract, MPS agrees to provide program development information and education to the Partnership Team to enable them to assume all the MPS (including MIS) roles. The county thus was protecting against the

possibility the arrangement could be short-lived and wanted to be sure that it would own what it expected to be a superior MIS, given MPSs known expertise and experience.

The 60-page RFP core outlined above is supplemented by a five-appendix brochure of 19 pages, which includes a model "intent to bid letter," which asks specifically about the bidder's MOS/MIS experience; the requirements for developing and managing a child welfare provider network, which includes all functions and services (14 pages); a requirement for submission in a specified spreadsheet form of proposal costs for each component—as well as implementation, staffing, and computer installation schedules for each site; a requirement for estimated operations costs and capital investment at the current volume of services and assuming a 100 percent increase; and a list of seven locations to be covered and the estimated number of PCs and laptops for each. A second, large appendix volume provides elements to be included in the database, filing, and tracking system; the mission and revenue sources of the ADAS system; clinical, billing, and prevention services flow charts; and the revenue sources, staffing, computer complement, and service descriptions for agencies currently in the alcohol, drug, and mental health systems.

A critic "after-the-fact" might wonder whether all these inquiries would predict whether a bidder, with excellent administration, management, and MIS credentials but no child welfare service expertise would do well. There is no attempt at evaluation here, but it is no secret that there were serious growing pains, and that the new system was not doing well as we prepared this report.

8. Between Announcement and Submission Deadline

Even where there has been prior consultation, perhaps an RFI, there may be questions. Potential bidders may need factual information relevant to estimating potential caseloads, client requirements, likely costs, and outcomes that can be achieved. All jurisdictions that we have reviewed organize one or more optional meetings as pre-bid conferences to offer elaboration and to answer questions in a context in which all involved will share equally and fairly the available information. Kansas, we noted, permitted written and e-mail submissions, and the

elaborate reproduced responses became part of an enriched RFP, available for all. On the other hand, all jurisdictions designate one contract person or point for all bidders, forbidding any other agency access so as to ensure even-handedness.

We have observed both "tough" jurisdictions that seem intent on a level playing field, if a forbidding one, and more supportive places that are preoccupied with getting the results they feel they need and believe that this requires a supportive process and rules. To avoid favoritism or corruption, jurisdictions variously rely on contracting statutes, administrative appeals, ombudsmen, and the courts.

In some instances, the application text is separated from the financial aspects of the proposal, either as a policy matter (rate a proposal's substance, and then see whether the price is reasonable or negotiable) or to protect confidentiality and competition.

On the other hand, we have already commented on the difficulty of objectifying and standardizing everything, so that blind ratings will lead automatically to contract decisions. Organizational capacity must enter as a factor. Details need to be negotiated in relation to an agency's proposed plans—or to put together several contracts to establish a delivery system or network. The contract negotiation stage must allow for a degree of discretion, as we have illustrated. And all the RFPs permit bids to be changed in the final stages to meet the conditions set in the negotiations. Here there are limits and statutory requirements to protect the integrity of the process.

Notes

[1] In this and subsequent sections we draw on RFP illustrations from specific places. As noted at the beginning section of this guidebook, we use materials with "face" validity, but there is no empirical basis for affirming that a particular RFP is more "successful" than others in relation to client-level outcomes or even (given variations in community factors) in generating responses.

The L.A. illustrations are from Los Angeles Department of Children's Services, *Request for Proposals: Community Family Preservation* (October 1996).

[2] In fact, the department engaged in a community organization process to help communities arrive at consensus about and recruit and encourage lead agencies, and the result was a very diverse pattern as intended.

[3] *City of New York, Administration for Children's Services, Request for Proposals for Child Welfare Services in the Borough of the Bronx* (1998), pp. 1–2.

[4] Hamilton County, Ohio, *Request for Proposal for a Management Services Organization* (1996).

5

Shaping the Agreement

As we have seen, the new child welfare initiatives, whatever their precipitating factors or motives, and often whether called "reformed purchase of service" or "managed care," either include or at least confront and decide not to include

- efforts to create systems of integrated, coordinated, networked, or case-managed services
- efforts to shift provider incentives (especially away from any or long out-of-home care) by capitation, risk sharing, bonuses, or other devices
- efforts to shift provider incentives and increase accountability by use of outcome- and performance-based contractual arrangements
- efforts in some jurisdictions to decentralize service delivery to the local community or neighborhood.

Depending on the plans in a given jurisdiction, some or all of these elements would have been included in the request for proposal (RFP) and will then enter into the ratings and the contracting.

1. Rating the Proposals

The typical pattern is to assign total proposals or fixed sections of proposals to staff or expert teams for rating. What seems to work is a team consisting of several senior staff members (supervisory or management levels), chaired or led by a more senior management person (assistant commissioner, regional director, etc.). The teams that have contributed to the design of the request for information (RFI) or RFP components—or teams like them—are suited for this work.

Before rating begins, the team must be given or must develop criteria for rating and a point system. This should come out of the prior work on the RFPs. We have offered illustrations in Chapter 4.

The process generally calls for independent, "blind" rating by 3–5 people and then a coming together. If circumstances require and time permits, it may be wise to

determine rater "reliability," following a process similar to that in a research project. Where results call for it, a training period and re-rating process may be needed.

The resulting ratings could lead to the specific identification of the agencies to which contracts will be offered. In an alternative procedure, where the ultimate package needs to be shaped with the components in hand, the raters will be expected to identify more potential providers than needed. These, then, will be screened during a "negotiated procurement" process. As previously noted, responsible authorities cannot predict all the specifics and the new, creative initiatives that could be part of a proposal. If these are welcome, the negotiators from the government side need to carry their planning forward once all the potential components are in hand. In the case of the Administration for Children's Services (ACS) Bronx RFP, for example, agencies specified volumes of proposed services in specific community districts or neighborhoods within community districts. In the negotiation phase, ACS had to explain what would be taken from a proposal for which area, so that it would all add up to borough-wide coverage. Also, as observed in a number of jurisdictions, final negotiations may deal with capitation rates, size of caseload to be covered, schedule, transition costs, contingencies, and more as potential providers propose changes and adjustments.

The evaluation of bids to provide child welfare services is not quite like a rating of submissions to pave roads, supply schools with books, or clean public buildings. The service, as suggested earlier, is often not standardized and the units to be supplied are "counted" in different ways in different settings. The contract specifications need to build on the agency's submission in reaction to the RFP but to be modified by the input of the public agency in response to the totality of submissions and in the light of its vision. This poses a challenge to legislative bodies, county boards, and so forth: Specify contracting rules to protect against fraud and favoritism and ensure transparency, but create rules for the final stage that will permit innovation and creativity.

2. Risk and Risk Sharing

One associates the notion of risk with the for-profit enterprise that assumes risk to be in a position to earn profits. The entrepreneurs involved learn to analyze the odds in an effort to approximate a "sure thing." The relevant variables vary by

context, time frame, and type of enterprise. Managed care comes to child welfare via behavioral health via medical care via private insurance where the private company is the profit maximizer. When government privatizes medical care via the risk sharing of the health maintenance organization (HMO) (Medicare or Medicaid for-profit HMO plans, for example), the same pattern of motivation is to be assumed as is a degree of constraint and guidance by medical ethics and public service commitment. But more than this is going on: nonprofit HMOs and nonprofit child welfare agencies of various kinds are being invited to offer proposals for service involving risk or risk sharing, and they are responding positively. Why?

Both the contractor and the potential provider have stakes in risk estimation and incentives for doing it well.

Broskowski[1] has provided an overview of what he considers to be the opportunities in risk-sharing arrangements, but experience on which he was able to draw is limited to the areas of physical and mental health. Although there has been some learning since his report, the experiences are limited. We have already referred to some. We draw on what we have encountered but encourage negotiators to adopt an experimental and developmental mode and to allow each side fallback positions.

First, some concepts. In a risk-based contract a set price is agreed to for a case (or for cases of given types) or for a "defined population of potential users over a defined time period." Each side must make its prediction, as it negotiates, on the basis of "how many eligibles will become clients... and how much care will each client use... and what a unit of service will cost."[2]

As seen by advocates of the new "business-inspired" approaches to payment for agency services, a typical fee-for-service provider submits a bill and is reimbursed retrospectively for the number and types of services rendered. There is little incentive to reduce the intensity, duration, or amount of care unless it comes from professional norms and ethics. A U.S. Government Accounting Office survey[3] comments that, by contrast, each of the prospective financing arrangements does expose the provider to some risks and does change incentives insofar as they are payment guided. The *case rate payment* (one payment, defined in advance, for a course of service) transfers to the provider the risk that the patient's service level, duration, and cost will exceed projections. The provider is given the incentives to

reduce the duration of treatment and to avoid costly long-service patients. Of course, some of the child care reformers are also motivated to shorten duration. They want to hasten permanency planning for children in out-of-home care and to better serve children while also saving high foster care costs. Pressure to cut duration could be consistent with such aims. The *capitated rate*, which takes the form of a negotiated fee for all potential members of service groups for a specified period of time (monthly, annually), also creates an incentive to discourage service use or to refer elsewhere. Again, although some of this may be wanted by those who would reform child welfare in the interest of children, they could see some of it as counterproductive. It would appear, however, that limited case or capitation rates could serve to concentrate the mind on why children remain in out-of-home care and whether it is necessary, something reformers would welcome. Somehow, professional and business-based incentives require alignment—because costs do matter and resources are scarce. This is part of the incentive for new modes of contracting.

Both the contractor and the potential provider have stakes in risk estimation and their own incentives for doing it well. Experts in the field take on the task of risk estimation by a variety of actuarial approaches and prospective risk simulations. The latter would be most promising were there enough accumulated experiences in child welfare risk sharing to identify variables and their proper weightings. Although the mathematical formulae used in some of the health care risk calculations are impressive for that field, child welfare developments can only be experimental for some time. We are therefore not surprised to observe that contracting government agencies use their current costs (modified as appropriate by potentially changed reimbursement) as the bottom line. Where governor or legislature have changed the allocation, that becomes the point of departure. We encountered two situations in which the state divided its child welfare budget among counties on the basis of prior caseload flows. Colorado serves as an illustration (see below). For the counties, this set the parameter of what they could offer and what they would expect providers to risk. If cost were going up generally, then fingers were crossed.

More than a risk–reward corridor is needed to protect potential clients–consumers and the general public.

To return to the question "why" from the nonprofit agency perspective: If they analyze their prior experience, collect adequate data along with the RFP as to numbers, previous costs, and state projections, they may conclude that they can come out ahead, or at least not sink into debt. Although there is no "profit" motive, the contracts are usually written to allow them to use any "gains" to advance their program objectives. The nonprofits usually can use funds for such purposes.

On a narrower level, if the provider agency has depended on public funds in the past, and most have, and if the public agency insists on a risk-based approach, the provider probably must go along if it wants to remain in business. In that case it must seek to negotiate rates or to ensure inclusion in the contract of some of the possible risk-sharing protections.

We have found that public authorities are not unreasonable here as they negotiate with the "winners" in the proposal ratings. They provide requested data for final calculations, consider provider analyses, and permit changes in "best and final" offers from potential providers. They even set quotas and exclude some particularly "risky" cases from the capitation system. They pay fees billed in the traditional ways for service delivered to such cases.

What both sides need under circumstances of great uncertainty is a "risk–reward corridor" in which losses and gains for either side are limited and the financial implication specified: What will the contracting agency add to the lump sum or to the capitation rates if the losses exceed what percent? What will the provider forgo (refund) if the gain exceeds what percent? (We have offered a Kansas illustration in Chapter 4. Foster care contracts included for the first year a risk corridor of 90–110% of the contracted case rate.) Such an arrangement can keep providers from going out of business and thus encourage proposal submission (where providers do have an option to stay out of the new plan by virtue of other contracts and resources). Such arrangements maximize the opportunity for the public agency to achieve the cost savings that are being sought. In the health field catastrophic loss may be avoided through insurance, risk pools, and other contractual arrangements with the contracting agency, but we can as yet point to no sizable body of analyzed experience here for public child welfare.

In the case of Magellan Public Solutions (MPS), a major for-profit organization in health and behavioral health managed care, the contract with Hamilton

County, Ohio, specified that the managed care organization (MCO) would be responsible for taking over all but protective cases and "simple" foster care and for case managing a provider network, which it would create. Payments to providers are on a fee-for-service basis—and MPS is the county's agent in paying providers. MPS also has contracted to develop and operate a management information service (MIS). MPS is responsible by contract for a 15 percent cost savings, about $2 million below costs in the most recent period. The contract includes caveats about inflation, actual numbers of covered cases, and court orders. There is a $100,000 bonus if the contract's performance standards are met, and MPS earns 5 percent of additional savings between their guarantee of 15 percent and 21 percent of dollars paid. MPS will receive its basic payment for administrative services in accord with specific agreements incorporated in the project budget (no specific risk here). It may exceed any line item in the project budget by 10 percent without prior permission. MPS will not be paid for any "start-up" or "up-front" costs. The signed contract provides for a "good-faith" effort to convert to a capitation or another "at-risk" arrangement within 18–24 months of a departmental initiative to do so. The expectation that by then a good MIS would have been created and would facilitate far more accurate calculations was a factor in this thinking.

As a state, Colorado is exploring managed care through six county pilots. In the past, the state had a state-administered county-operated system for welfare programs with a 20 percent county financial match. Because of a "dramatic increase in out-of-home placements and associated costs," the legislature voted a capped allocation to each county, while giving counties increased flexibility in spending money and negotiating rates, services, and outcomes with providers. (A similar approach is being followed with Temporary Assistance to Needy Families.) The counties now involved have designed a variety of foci for their experiments. If successful in cutting costs a county keeps all but 5 percent of savings. County, state, and independent evaluations of various aspects are being undertaken. The department's find report to the legislature will advise as to whether managed care should be adopted for child welfare statewide.

But more than a risk–reward corridor is needed to protect potential clients–consumers and the general public against possible undesirable effects of the introduction of cost preoccupations into an arena of social welfare long a public

responsibility and legally dedicated to children's "best interests." As we write, the press reports financial bankruptcy of some medical MCOs whose risk predictions were in error (particularly as to changing costs). At the same time the Congress is debating alternative approaches to a patients' bill of rights to protect users of medical and behavioral health managed care plans where the HMO and insurance companies are controlling costs to a point where self-insurance against risk undermines some of the expected scope and quality of services.

Intermingling agency process targets with child outcome targets.

For the contract this means that quality assurance and accountability control components are essential protections for clients–consumers, too. In outlining RFPs we have described the importance of specifications of case protocols, utilization reviews, agency accreditation, and agreed staff qualification. All of them belong in the contract as does the topic of outcomes and performance contracting, to which we next turn.

The risk discussions in the health field in fact urge the inclusion of client–patient voices in the risk discussion. Users have stakes in the size and stability of copayment and deductibles policies and the availability and quality of the guaranteed services. The child welfare client is either *technically*—by virtue of protective service or court prerogatives—or *de facto*, out of need of services and for lack of alternatives—in effect an involuntary client not in a position to bargain at contract time. However, the philosophy of neighborhood and community involvement in service planning and governance calls for that as an avenue for client or client-surrogate participation. Other RFPs specify client "satisfaction" surveys.

Before turning from the risk discussion, one or two additional insights are in order. Broskowski correctly observed[4] that in any system risk is best shared and balanced among all actors. Our own observation is that any system that seeks long life can be based only on mutual advantage. A sense of unfairness or unreasonableness is bound to interfere with mission. Inevitably programs that serve larger populations and that are sufficiently inclusive to preclude adverse selection permit better estimates of risk and engender greater security for those who risk share.

3. Outcome and Performance Contracting

We began (Chapter 1) with a review of the spirit of current child welfare reforms, whether seen from the perspectives of those who begin at the local service delivery

end or those who formulate broad policy at the federal or state level. If risk sharing in RFPs is designed to give both MCOs and providers financial stakes in the policy outcomes sought (reunification, family preservation, permanence, briefer stays in out-of-home care), "outcome" and "performance" contracting builds the sought results into the agreement in very explicit terms.

Although important and rigorous work has been and is currently being done in measuring child and family development and well-being this progress is mostly reflected in clinical work and in research. For understandable reasons, its application to RFP writing and to contracting is limited. The problem is this: Contract management requires measures that can be routinely reported in the MIS, are generated easily and objectively, can be applied by several types of personnel who are not trained in child development, and are reliable over time. More sophisticated reports would require relating data to the different statuses of children and families as they enter service systems, continue in them, and leave. The report would be a summation of complex and costly individualized assessments, something not feasible or affordable for typical jurisdictions or large numbers.

Nonetheless, outcome measures are taken seriously and appear either in RFPs or in agency proposals—or both.[5] Kansas again serves as a useful and not atypical illustration. It describes what it has designed as an "outcome-driven system" and focuses particular attention on monitoring implementation and on those outcomes related to child safety and permanency. We cite their RFP for foster care services. Clearly, as judged by these indicators, the incentives for agencies are to be changed.

The outcome goals specified in the Kansas RFP and subsequent contracts for foster homes and group care are child safety, free of maltreatment, a minimal number of placements for child, maintenance of family–community–cultural ties by the child, and child reunification with its family in a "timely manner." As evidence of goal achievement—to illustrate—the provider must show that 95 percent of the children in care and supervision do not experience substantiated abuse and neglect while in placement; 90 percent of the children referred to the provider will not have more than three subsequent placement moves; 65 percent of children with siblings will be placed with at least one; 70 percent of children placed are kept within the regional boundaries of the provider agency; 75 percent

of youth released from custody have completed high school, or obtained a GED, or are involved in an educational or job training program; and 60 percent of children placed in out-of-home care are returned to their families within six months. Operational definitions are provided for all measures.

Beyond this, contractor and MIS reports, onsite reviews and monitoring reports, and results of family satisfaction surveys and staff interviews (all pulled together by an outside evaluator who reports quarterly) are assembled for overall evaluation of the contracting system and of the department's functioning as management services organization (MSO) and as responsible for the out-of-court settlement terms. By the time of the second quarterly report the evaluation had data on performance and outcomes by program type and region. One could discuss agencies and regions above and below outcome norms and above or below their service quotas. Adjustments in some norms could then be considered.[4]

Under the Adoption and Safe Families Act of 1997 (see Chapter 1) the U.S. Department of Health and Human Services was mandated to develop a set of child welfare outcome measures that could serve to assess state performance in operating child welfare programs (including child protection). The proposed measures are built on the data from the two reporting systems now federally backed, the National Child Abuse and Neglect Data System and the Adoption and Foster Care Analysis and Reporting System, described in Chapter 3, section 6 (p. 65). This limitation to these data systems results in indicator listings much like those now found in state contracts. It tends to disappoint those who would like to see on the list more specific child well-being measures and some indicators of system capacity and resources. In any case, this current federal list (and its future enhanced versions, expected to attempt education and health indicators) should provide a new core for future RFP performance and outcome indicator lists.[5]

Colorado's pilot work on managed care offers a similar list of outcome objectives and the related performance indicators but uses terms such as "maintain," "decrease," and "increase" rather than offering specific initial percentages (e.g., "95 percent . . . do not experience abuse or neglect"). Here, too, parental satisfaction is to be a performance indicator. The individual counties added the "numbers" for several of the indicators (as well as risk-sharing requirements) as they wrote their contracts.

Colorado's overall perspective on performance-based contracts as a requirement for counties that wish to experiment calls for evidence of financial compliance with federal reporting and auditing requirements, outcome measures, savings, quality assurance including grievance procedures, specific client and program data, compliance with federal and court-ordered program requirements, and evidence of effective management of subcontractors. This list could apply to many lead agencies, MCOs, and others in other states. Almost all contracts require relevant professional accreditation for the agency, staff qualification for employees, and MISs as starting points.

In an intermingling of agency process targets with child outcome targets, Tennessee's "Strategic Plan" (for example) lists as performance measures for lead agencies that will construct "continua of care" the commitment to (sic) "reduce by 25% average length of children in custody who can be returned to their families over the next 2 years" and also "to complete assessments for 100% of the children within the first 15 work days" (Figure 4).

The Hamilton County, Ohio, MCO contract with the for-profit MPS includes cash incentive and/or disincentive provisions (depending on the availability of solid benchmarks) related, for example, to "timely behavioral health services" or "services appropriate to the needs and provided in the least restrictive setting." In the two excerpts from Exhibit 7 in the MPS contract, we illustrate with six of the 12 service outcomes in focus (Figures 5 and 6).

Los Angeles' contracts, in a departure from this pattern, require an annual self-evaluation report from each lead agency. Each is provided $10,000 for this purpose. After a series of confused starts, the lead agencies pooled their funds and contracted with a research consultant. That work is still under way. The overall goals are specified in general (not statistical) form in the RFP and contracts.

An observer in a sophisticated multifaceted voluntary social agency with many contracts looks at the reporting protocols specifying 90 percent of "this" or 80 percent of "that" and argues that in a mental health or prevention service individualized outcomes are almost impossible to specify and measure over large populations, so agencies look at what can be counted as indicators of quality and that these things are often insignificant or irrelevant. Indeed some leaders in a number of states confess that their initial percentage targets were "pulled out of a hat."

Figure 4

Department of Children's Services Strategic Plan

Goal 1: Provide appropriate care for children in custody close to home and return them to their families or provide for permanency of care in a timely manner.

Objective 1.1: Reduce by 25% the average length of stay for children in custody who can be returned to their families over the next two years

Strategies:

1. Increase the number of "continuum of care" contracts for FY 98–99
2. Increase the non-custodial services that are available to the courts for after-care in FY 98–99
3. Provide training for case managers and supervisors on the use of data for monitoring children in care beginning in 1998
4. Establish an effective Utilization Review Process in each region by July 1998

Objective 1.2: Complete assessments for 100% of the children within first 15 work days

Strategies:

1. Establish a standard assessment process for each region in 1998
2. Provide pre-service and continuous training on assessment protocol to case managers in FY 97–98
3. Monitor the number of placement appeals to evaluate appropriate care
4. Establish medical consulting support for each region by July 1998

Objective 1.3: Double the number of children being adopted by the year 2002

Strategies:

1. Increase the legal capability and support of the regions for the administration of parental rights terminations for FY 98–99
2. Link with private providers to develop a more effective recruitment and placement process
3. Utilize "continuum of care" contracts for adoptive services by July 1998

Objective 1.4: 85% of children that leave custody do not return to state custody

Strategies:

1. Develop an effective intake system to ensure timely and appropriate placements by January 1999
2. Increase the amount of appropriate after-care services in FY 98–99
3. Develop a communication process with DOE/TennCare to discuss problems and issues impacting children at risk of returning to DCS

Objective 1.5: 100% comprehensive independent living plan for children 16 and older by January 1999

Strategies:

1. Provide training on independent living to case managers by January 1999
2. Implement a permanency plan for 100% of the children
3. Provide contract services for children requiring independent living skills by January 1999

Objective 1.6: Partner with private child care providers to determine ways to improve the service delivery system with outcome-based contracts

Attachment—Managed Care Outcome/Results. Resource Management Division

Goal 2: Provide community prevention and intervention services to keep our children and communities safe

Objective 2.1: Reduce by 80% the number of "unruly" children placed in custody by January 1999

continued

Strategies:

1. Work with Juvenile Courts and schools to identify "unruly" children
2. Implement Family Crisis Intervention Teams in each region by July 1998
3. Provide adequate services to support the work of the Crisis Intervention Teams
4. Create "Continuum of Care" Services within and through each Community Service Agency (CSA) for non-custodial services beginning July 1999
5. Develop a plan to involve schools in addressing problems that are impacting the "unruly" children by January 1999
6. Develop training/education in conjunction with the Juvenile Courts in addressing the problems of "unruly" children by January 1999

Objective 2.2: Reduce the incidence of severe child abuse by X% and reduce the number of child fatalities due to abuse or neglect

Strategies:

1. Provide prompt response and investigation of alleged incidence of neglect or abuse
2. Increase the number of Child Protective Investigative Teams and Child Abuse Review Teams by X% through reassignment of staff
3. Improve collaboration with law enforcement officials, District Attorney offices, and medical personnel
4. Develop a partnership between DCS and Child Advocacy Centers to address the problems of child abuse by July 1999
5. Ensure that a DCS representative is on child Fatality Review Teams

Objective 2.3: Increase the percent of DCS budget to X% for Prevention and Intervention Services

Strategies:

1. Complete Needs Assessment to determine services required in each region by January 1998
2. Collaborate with other state departments to maximize and coordinate services and funding
3. Reallocate monies within the budget for these services and provide a financial incentive
4. Utilize the Internet to search for community grants, foundation grants, federal grants, etc., to supplement state monies

Objective 2.4: Provide services to delinquent youth, with adequate security to maintain community safety

Strategies:

1. Provide security, education, and training for delinquents in Youth Development Centers
2. Decrease the recidivism by X% by 1999
3. Increase vocational training by X% so that youth can get jobs by 1999
4. Assist the Task Force on Juvenile Justice Code Revision in identifying issues to promote community safety as well as rehabilitative concerns
5. Develop a master plan for Juvenile Justice capital outlays for next five years utilizing projections/trends of youthful offenders
6. Provide services to integrate delinquents back into the local schools
7. Cooperate with Juvenile Courts on community safety issues by assigning court liaisons for regular interaction and feedback

Objective 2.5: Create services to support re-entry of youth into school, community, and family

Department of Children's Services. Strategic Plan for Improving Services to Tennessee's Children. Submitted by Commissioner George W. Hattaway. February 1998.

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A clinician may cite cases in which reduced placement rates and shorter placements are not necessarily positive outcomes for all children. Some of the statistical measures lend themselves to "gaming" the system by case choices, case recruitment, or internal reporting procedures.

Our reaction is that much of this is true but that some of the performance outcomes used as statistical indicators of goal achievement are as close as one can now come to monitoring progress on explicit federal, state, or local policy goals. The cases in which exceptions are called for because of case-specific insights need to be accommodated in the setting of the statistical targets or operational definitions. Those of us committed to results-oriented contracting must not ignore the need to maneuver between the emphasis on accountability and the agency–practitioner need, in a field that has much learning to do, for flexibility and innovation. And the work on evaluation must continue.

4. Tough and Supportive Contracting

We return to a theme that has been sounded at several points and that cuts across the RFP, RFI, and contracting phases. We have observed different styles that are variously shaped by legal requirements in the jurisdiction about contracting, the political climate of the moment, and cultural factors. In brief, some RFPs announce risk arrangements and tell potential providers to take it or leave it. Some announce case rates or group capitation rates, tell how they are computed and leave them on the table. Some provide case statistics, demographic trends, long-term cost information, and supplementary documents; have one pre-bid conference; and leave potential applicants on their own at that point. Others announce expected outcome achievements and retain the right to contract cancellation if there is failure, but do not explain how they know the results to be practicable. Some supply transition budgets to allow more agencies to bid and some do not.

But contractors and providers (or MCO contractees) need one another, whether the commitment is based on a sense of community obligation or loyalty to one's agency and its traditions. Service is needed and cannot be interrupted. Thus, we also see reformulated or renegotiated case or capitation fees or risk-sharing arrangements following discussion in pre-bid conferences or at the time when the

Figure 5

Exhibit 7: Established Performance Standards

Area: Service outcomes

Service outcomes refer to those measures that assess the improvement of consumers under care management by the MSO. Only DHS referred consumers to be enrolled in the provider network managed by the MSO are considered.

INDICATOR	MEASURE
1. Children and families will receive timely behavioral health services **Incentive:** $18,000 **Disincentive:** $18,000 **Frequency:** Quarterly	■ Assessments of services needed will be available within 3 hours for emergencies, within 24 hours for urgent needs, and no greater than 5 days for non-emergency needs ■ Care manager will be assigned within 24 hours of completion of assessment ■ Panel services will be available to consumers within contractual time frames after assessment of service need ■ Emergency therapeutic foster care placements will be available within 8 hours, non-emergency placements within 21 days ■ Efforts to make off-panel referrals are documented
2. Services are appropriate to the needs and provided in the least restrictive setting **Incentive:** $15,000 **Frequency:** Quarterly	■ MSO follows clinical protocol, resource utilization criteria for levels and location of care, as approved by DHS ■ Measures to be established in beginning of year one. Possibility of developing measures in collaboration with a third party to be explored
3. Services are available to meet the needs of children and families **Disincentive:** $9,000 **Frequency:** Quarterly	■ Services should be closer to home and within reasonable travel time ■ MSO will develop additional services currently unavailable or insufficient to meet child and family needs
4. Family involvement **Incentive:** $7,000 ■ Children and families will accept and participate in offered services ■ Services are family-centered **Frequency:** Semi-annual	■ Penetration rate: Proportion of family members beginning an authorized outpatient service by age, diagnostic category, treatment type and setting, placement status of child, level of CAN risk ■ Involvement of children and families in treatment planning and treatment ■ Consumer satisfaction
5. Continuity of care for services provided **Disincentive:** $9,000 **Incentive:** $5,000 **Frequency:** Semi-annual	■ MSO care managers assure service linkage between services ■ Follow-up with Tx plan to discharged consumers is provided within 2 business days for urgent care, within 10 business days for non-urgent care ■ Placement moves and discharges for non-therapeutic reasons
6. Ensure children's safety and reduce risk of harm **Incentive:** $4,000 **Disincentive:** $10,000 **Frequency:** Monthly	■ MSO has a QA structure and process to monitor quality of care ■ Number and types of incidents in the provider network ■ Reports from county child abuse investigations

From Hamilton County Agreement with MPS

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selected agencies are called in for contract negotiations. We see deferment of risk sharing until the second contract year or until an adequate MIS is in place. We see adjustments of expected numerical outcome achievements as experience offers a corrective to wish lists or best guesses. Finally, if the goals include incorporation of community-based organizations or ethnic–racial services into the community mix as part of a decentralized strategy, there is a readiness to offer transition budgets, technical assistance, and training support so that they and their potential contribution will not be lost to the new system.

All of these considerations, we have suggested, call for an active community organization effort by the relevant department before there are RFPs and for a degree of flexibility and discretion in the final stages of negotiations. The latter should be focused on achieving state and county objectives for the child welfare reform. It should be made transparent and validated by local law and administrative procedures that have been revised if necessary. Child welfare may benefit from "business" or "market" thinking and tools, but its societal mission should govern. We believe this to be the public intent; it is certainly the public interest.

Notes

[1] Anthony Broskowski, "The Role of Risk-Sharing Arrangements," in Leslie Scallet, Cindy Brach, and Elizabeth Steel, eds., *Managed Care: Challenges for Children and Family Services* (Baltimore: Annie E. Casey Foundation, 1998), pp. 28–31, 69–89.

[2] *Ibid.*, p. 28.

[3] U.S. General Accounting Office, *Child Welfare: Early Experiences Implementing a Managed Care Approach* (Washington, DC: GAO (HEHS-99-8), p. 19. Also pp. 42–46 for a survey of methods in use to establish capitated payment rates.

[4] See note 1.

[5] For an extremely useful compilation, including additional outcome dimensions, see Charlotte McCullough and Barbara Schmitt, *Outcomes in a Managed Care Child Welfare Environment* (Washington, DC: Child Welfare League of America, Managed Care Institute, 1998). Also summarized in an article by McCullough and Schmitt in *The Children's Vanguard* (October 1998), pp. 5–8. In contrast to many of the listings we found in RFPs, this listing also would ask about child and family functioning (using, for example, standard assessment scales) and includes as well indicators of system resources and capacity, which could, in fact be included among contract terms. For other suggestive, more comprehensive leads, see *Children and Welfare Reform: A Guide to Evaluating the Effects of State Welfare Policies on Children* (Washington, DC: Child Trends, 1999).

Figure 6

Exhibit 7: Established Performance Standards

Area: Service outcomes

Service outcomes refer to those measures that assess the improvement of consumers under care management by the MSO. Only DHS-referred consumers to be enrolled in the provider network managed by the MSO are considered.

BENCHMARK	DATA REPORTING REQUIREMENT
Incremental benchmark **70% tolerance at the 2nd quarter, increased to benchmarked proportion by end of 4th quarter 1997** ■ 95% of assessments for emergencies are begun within the time period and 95% of all other assessments are completed within the time frame specified ■ 95% of care managers are assigned within the time frame; the rest assigned within 2 days ■ 95% of services will be available within contracted time frames ■ 90% of placements are made within the time frame ■ 100% of off-panel referrals not made are documented	■ Case plan date (from DHS form), hour date of request of MSO assessment received, hour date of actual assessment, including face-to-face assessment ■ Ditto for outpatient services and placement referrals ■ Ditto for MSO's referrals to off-panel services ■ Documented reasons for MSO noncompliance, including therapeutic reasons and client choice
Incremental benchmark ■ 95% of compliance with the clinical protocol; the rest with documented reasons for non-compliance **Benchmarks to be developed**	■ Services determined by protocol, services actually authorized ■ For each child in placement, types of placements (and restrictiveness and intensity) ■ For each child, dates each placement begins and ends ■ For each child in day treatment, date service begins and ends, subsequent school setting **To be further refined based on measures and benchmarks that are to be developed**
Incremental benchmark ■ Outpatient services shall be available within 30 minutes of residence ■ 60% of residential placement services should be provided in Hamilton County ■ 95% of residential placement services should be provided in Hamilton County or adjacent counties (Claremont, Warren, and Butler) including Dayton ■ Document service gaps (including service accessibility as a barrier to service); develop new service/providers to fill gaps	■ Accessibility as a barrier to services ■ City and county of authorized and delivered placement ■ Services determined by protocol services actually authorized
Incremental benchmark ■ 70% of family members will start outpatient services **[Use period through 6/30/98 to establish baseline for monitoring in years 2–5]** ■ MSO policy regarding family involvement ■ 95% of case plan records of children living at home show family involvement in planning ■ 90% of consumers are satisfied with involvement with MSO and providers	■ Authorized services that are started ■ Age and diagnosis of authorized consumer ■ Treatment setting and type of treatment ■ Child's placement status, risk of CAN ■ MSO policy ■ Evidence in case record of family involvement ■ Types of services received by family units ■ Report on results of consumer satisfaction studies

continued

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Exhibit 7: Established Performance Standards (continued)

BENCHMARK	DATA REPORTING REQUIREMENT
■ 95% of terminated services will have a discharge plan within 10 days for non-urgent care and 2 business days for urgent care, linking family members to other services as needed ■ All providers will not move or discharge a child without prior DHS approval unless child or other child's safety is at immediate risk (No eject/no reject)	■ Date of discharge ■ Urgent or non-urgent care ■ Date of follow-up/discharge plan ■ Reports of children's discharges and moves (monthly)
■ MSO has policy and procedure in place to ensure quality of care ■ 95% of incidents involving the child are successfully dealt with by MSO and provider panel	■ MSO policy and procedures for quality of care and handling incidents, including child abuse and neglect ■ Reports of CAN and findings ■ Resolution of reported incidents

From Hamilton County Agreement with MPS ■

In an interesting twist, the former Kansas Commissioner of Children and Family Services who spearheaded their new initiatives is now promoting an alternative to purchase of service and managed care under the banner of "Outcomes Based Management (OBM)." (Seminars are scheduled in four cities.) There is a paradigm: Define it. Design it. Implement it. Manage it. Compare it. Benchmark it. (Mailing from Corporation for Standards and Outcomes, Pittsburgh, PA, 1999.)

Federal Register, February 2, 1999.

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6. Responding to RFPs: The Service Provider

Our discussion of the response to the request for proposal (RFP) has focused on the potential service provider or potential lead agency that has some managed care organizations (MCOs) and some direct service responsibilities. In short, we have stressed the bid to provide direct services. The scale can be small (a caseload) or large (one or more Kansas regions). Beyond our scope has been the large for-profit MCO that takes over a large part of the case management and administration role (as Magellan Public Solutions in Ohio, which also is developing a management information system, or MIS) or the for-profit contractee that bids to offer specific administrative services. In general, the concerns of the for-profit bidder have their own entrepreneurial logic, which belongs in a domain beyond this discussion. There is too little such experience in child welfare on which to base generalizations; the major initiatives are exploratory and developmental, usually components of expansion by firms involved in managed care in medical and behavioral health. There clearly are some who see advantages in taking the plunge.

Here, then, our focus is on the provider agency, nonprofit or for-profit, and its responses to a child welfare RFP, especially a managed care RFP or a purchase-of-service RFP with some of the managed care characteristics. The experience of agencies must be assembled by interviews and looking at proposals. Systematic, research-validated knowledge does not yet exist.

These RFPs cover many or all child welfare services in some instances (but not usually the child protection or MCO role retained by the public department thus far). Some initiatives involve only congregate care or what are in the field referred to as "deep-end" services, services for the most disturbed or most difficult cases. The opportunities offered are either contracting as an individual agency to deliver specified services on a specified scale or to serve as a lead agency, assembling a network of agencies offering a sufficient quantity of a specified service array (out-of-home care) or a full network for a service system (all the components of family preservation, conceived of as interventions short of foster care but more intensive than primary prevention) or a combination of family preservation and out-of-home care.

1. Is This Something We Should Do?

Agencies qualified to offer proposals tend to be located somewhere on a continuum between (a) an absolute need to get the contract to survive (this usually means that they have been functioning on the basis of public funding under whatever pattern the public agency followed before this new thrust and therefore must pursue that funding in its new form) and (b) greater independence as large multifunction agencies with some regular flow of philanthropic funds and some endowment. Typically, even agencies in category b do not want to desert populations that they have traditionally served, nor would their boards, the local United Way, or sectarian welfare federations want them to. None are so well situated financially that they absolutely do not care.

In context of the desirable involvement patterns described in Chapter 3, these stakeholders would know well in advance about the planned new thrust and would perhaps have had an opportunity to influence it. In any case this process should also offer context for the exploration of the question, Is this something we should do?

For any agency in a position to think and consider, this would mean asking whether the proffered contract is at the least compatible with but perhaps even vital to its organizational mission. This will not seem to be a strange question to traditional voluntary sector social services agencies. They have a base from which to explore it and have a history of learning to answer it. Other agencies whose funding needs in recent decades have led them to pursue available categorical grants and who are not limited by firm identification with a larger movement (e.g., family services, child welfare, settlements, child guidance) will perhaps decide to seek the contract and then to integrate it into their service array, not worrying about full coherence. Often today, the name of an agency no longer predicts a commitment to function so specific that it dictates what will be of interest—the inevitable result of a complex system of fragmented federal categorical funding over recent decades. Grants are applied for and received as separate entities.

Ask whether the proffered contract is at the least compatible with the organizational mission.

In any case, one would urge a review of the compatibility of the service proposal in the RFP with the agency's program, commitments, sense of its competence, and—we would hope—mission. For a large agency this means a planning process if it is to be a significant and new service and if the agency program has not had a recent review. Some well-managed agencies function with a pervasive sense of where they fit in or would like to fit in and have an executive serving as planner who can review new offerings and recommend which merit a proposal. Of course the small agency expects its top executive to develop a point of view and, perhaps, a response in interaction with the board.

The sense of mission can be very important. We encountered one voluntary agency which, having determined that a public request for proposals merited a response because as an agency it had a contribution to make and public responsibility to do so, decided to submit a proposal even though its study of the terms told it that the reimbursement offer would not meet the program's requirements as it saw them. It decided to supplement the public reimbursement with private philanthropic funds. This type of response, quite consistent with the concept and rationale for private, tax-deductible philanthropy, remains unusual not because of ideological but because of financial constraints. Where private agencies are known to be able to supplement a public contract with philanthropic funds, this is often built into the proposed payment rate in the RFP. Many professionals in this field do care about the service system and will respond to opportunities to enhance it even if the price is not right.

2. An Independent Proposal or a Consortium?

We have observed two patterns and noted a third. Typically a department announces an interest in contracting with a series of providers for specified services on a given scale. Individual agencies apply. A number of such arrangements have already been described. Under the network variation an agency is offered an opportunity to become a or the lead agency for a specified community and to undertake the responsibility of creating a community network of all the required services and to subcontract for those it does not itself deliver (the Los Angeles lead agencies were locally designated in a community organization process, then encouraged to apply). Sometimes there is a limit on the proportion of services that

the lead agency may itself deliver. In a variation, an agency agrees to carry full responsibility for statewide services of a given kind for an entire state or for several regions (foster care, adoption, and family preservation in Kansas). In accepting its contract the agency agrees to subcontract with a variety of providers throughout the state or region, preserving the diverse array and protecting successful providers.

In a third pattern now growing in behavioral health and beginning to touch child welfare, a group of agencies comes together in a consortium to create a comprehensive service network of a given kind. This consortium then offers to negotiate with an insurance company, a health maintenance organization (HMO), or a public department seeking to contract for a specified volume of services or it bids for a contract in response to an RFP. Alone, individual agencies feel they have weak bargaining power, lacking the financial resources or size to assume risk or to put together an attractive bid.

How does an agency decide? Often the choice is predetermined by the RFP offering. The consideration with regard to mission—and service specialties—determines whether the possibility of participation should be on the agency agenda. A larger, reasonably comprehensive, experienced agency with the administrative capabilities and resources could consider the lead agency role. The agency that believes that, in an era of mergers, acquisitions, and consolidations, to be too small is to be vulnerable, may wish to actively promote a consortium that could negotiate with an insurance company, an HMO, or a unit of government from a position of greater strength. And there are those who argue that consortia and consolidated agencies in social welfare, or in business, may enjoy the advantages of diversity and new synergy—apart from the possible economies of scale—and have the potential for creating "seamless delivery of care."[1]

But the lead agency responsibility is no small thing. Just as the question of undertaking a contract service requires ability to meet the professional service responsibilities called for in the "scope of work," a lead agency role should not be undertaken without actual or potential capacity to lead a network, monitor contracts, handle financial responsibilities, monitor and report on performance and outcomes, and use or develop data systems.

A complex series of issues arise for the comprehensive city-wide agency in a city inaugurating decentralization to a neighborhood or community district base as

part of its child welfare reform. When New York City issued its RFP for the Bronx it encouraged large agencies serving much of the city (with congregate care or diagnostic services, for example) to create consortia in combination with small community-based organizations (CBOs) and to apply together. This approach was not adopted by many. If one wants a network or a collaborative, the RFP apparently needs to specify a contract for such. What New York's Administration for Children's Services got instead were independent applications from the small local groups and proposals to cover specific neighborhoods and community districts from the larger agencies. The congregate facilities, for example, had proposed only to develop community bases for case channeling, reunification, and after-care services. In negotiating the contracts the city authorities had to create the network combination they sought and to ensure that each district or neighborhood would have coverage.

3. Some Urgent Considerations

Does one simply answer the questions—or make a more elaborate presentation? The agency that decides to submit a proposal needs to decide, with reference to its knowledge of its area, the contracting department, and the public culture, whether what is called for is a document based on direct, straightforward answers to questions posed in or implied by the RFP or an attractive, well-designed, written–rewritten–edited presentation, perhaps with color graphics, prepared by a grant-writing specialist.

One can offer no advice other than to suggest providing all information required in a clear, accessible format. But agencies have a right to know how their proposals will be processed and to explore—in the pre-bid conference, with those who have prior experience, with the community of agencies—just what must be done, if the RFP itself gives no hint other than length and does not take the form of a series of questionnaires or forms to be completed.

In any case, whatever the "dressing," the agency leadership (perhaps buttressed by task forces or subcommittees) needs to develop the content of the proposal. The RFP often may be treated as the outline. The answer should derive from a broad agency planning perspective.

Some of the most impressive (funded) proposals we reviewed presented full and clear proposed service models. We list below major items needing consideration

whether or not explicitly stated in the RFP. Our comments aim at highlighting a few urgent considerations. Several of the topics are also covered in Chapters 4 and 5 from a more general perspective. The order will appear arbitrary, because each agency will structure its inquiry with a logic growing out of local circumstances and its situation.

Capital Requirements

Typically, the RFP will mention special capital requirements growing out of the scope of work (e.g., new offices in certain locations, specialized institutional space). The proposal will be expected to show how these items will be financed as part of the "price" or from other sources. But the agency will want to consider other needs not necessarily visible to those who write and evaluate RFPs. Where will the expanded accounting staff be placed? What about space for a training unit? Where will the group sessions with parents be held? A proposal is strengthened as it refers to the specifics of how the contract is to be accommodated.

Staffing

The RFP usually will specify that staff for the program meet professional requirements. It is urgent, experience suggests, that the local labor market be explored to determine the supply and cost of the staff to be required by the contract—if only to ensure realistic budgeting in a risk-sharing plan. In several instances we have noted urgent questions during the proposal preparation process about staffing rules, and there have been some negotiations about these matters in the final stages. The agency must be able to locate and afford the staff it needs and to believe that the staff it can afford and recruit will deliver the contracted outcomes.

Administrative Capacity

Can the existing agency management and administrative staff handle the new responsibilities? If the contract is no more than a change in funding mode, it is one thing, but when there are new or changed program responsibilities, the administrative costs should obviously be part of the overhead item in the proposal. Some RFPs simply offer a payment computed on a case or area basis, so that the bidder needs to provide for all overhead items in a case rate. Others, whether on a transition or an ongoing basis, allow for a special overhead budget.

Special attention should be directed to the on-staff or the contracted accounting capacity. Whether at the initial bidding stage, on an ongoing basis as accounts

are settled with regard to the "risk corridor" agreements, and as the issue of contract renewal nears, the volume of financial analyses and auditing will probably exceed the pre-RFP patterns.

While the MCO will have the major new tasks involving development and operation of an MIS, the provider agency will be required by contract to produce data for that MIS and for its own reports. Again, this cost must go into the analysis of case or capitation rates or into an overhead budget. It is our observation that service supervisors and managers must be prepared to offer significant professional help on substance to MIS contractees who are technically but not substantively expert.

Agencies have a right to know how their proposals will be processed.

Do We Meet the Technical Qualifications?

Accreditation is too slow a process to be begun on receipt of an RFP. The bidder agency therefore can only review the RFP and determine that it qualifies. Others can prepare for a second round some years ahead. As much holds for another frequent requirement: eligibility for Medicaid reimbursement for specified services. Here, however, some lead agencies or agencies in consortia solve the problem via subcontractual arrangements. We have already referred to technical qualifications for staff (degrees, licenses, registration).

Are the Financial Arrangements for the Transitional and Implementation Phases Satisfactory?

We have observed two patterns. In one, the provider is offered a payment schedule that is phased in from the time that the case flow begins. The agency is asked to submit evidence that it can manage financially to reach that point on its own. In the other, there is a transition budget available, and the RFP includes directions for computation and necessary forms. With limited experience in hand, we have the impression that it is the department that wants to engage new actors, particularly CBOs, in its emerging system that is supportive via transition funds, as it is in other ways. The CBO does not have an endowment or access to substantial philanthropy. More-established agencies are likely to have some funds, access to resources, or other ongoing operations that will carry them over, and departments may then not offer transition funds.

Have We Asked Our Questions?

Attendance at the pre-bid conference is always optional but would appear to be always essential. To avoid favoritism, most jurisdictions limit access to staff once the RFP is released, so the formal meeting is a precious opportunity to ask questions (and perhaps observe who will be the competition). In one impressive and valuable process, one jurisdiction requested written questions (including e-mail) and made all answers available to all potential bidders. The answers were very clarifying and considerably improved on the RFP as a communication, and in several instances the terms of the offering were modified by the answers.

The individual agency, as it prepares its proposal, will therefore want to assemble its questions early and to ask them. This can only improve the proposal.

Are We Comfortable with Regard to the Department, or MCO, Network on Which Will Depend Our Own Ability to Deliver the Services for Which We Are Contracting? The formal evaluation of the technical submission is a one-way affair: The agency that issues the RFP rates the applicants. However, potential proposal writers may want to pause to ask some questions with regard to the department with which they might contract, the network they might form, or the MCO contractor.

We mention several potential concerns. Elaboration would not seem to be called for. Some negative answers could be so central as to make a contract too risky. Others may suggest the need to raise questions in the pre-bid period or to self-protect by introducing the topic during the contract negotiation stage.

- *Have they involved all the important principals?* In several instances, judges not committed to the new delivery system put the provider agency at hazard because it could not function as the delivery design assumed. The department had not involved the court sufficiently in the planning or had failed to win their consent. In another location, county auditors who would be central to the operation of local agencies in a network system had not been involved at all during the planning. Major problems arose, and it took some time before they were solved.
- *How reassuring are the demographic or service need projections as they will shape the size of the task to which we are committed?* Where errors here put the agency at risk, because the agreement calls for accepting all cases of a specific type in an area for a fixed price, or because assumptions about the balance among care

categories will set staffing needs, it is useful to ask for the data behind the department's assumption and even, where feasible, to conduct some independent analysis.

- *Is the financial risk one is being asked to assume or to share reasonable?* How are the payment rates determined? Is there enough experience and relevant data behind the calculation offered? Do other assumptions or analyses give other results? Should one ask for a reasonable risk corridor? Does one want to propose a stop-loss clause or starting with a fee-for-service plan, while accepting rigorous outcome measures, to be followed by negotiations for a risk plan as soon as enough experience is at hand?

- *Is the contract's overall financial return adequate to permit one to function in accord with current standards?* If not, is there endowment or current philanthropic sources with which to supplement the public payment? Should such funds be used in this way? Rather, should one conduct a two-tier operation, letting service conform to the payment? Should one review this as a professional ethical issue? Should the board discuss it?

- *Last—but a central consideration—have they outlined a scope of work for us as a provider and located us in a delivery system that they seem equipped to operate effectively in their role(s) as the access system, the MCO, as the utilization review agency, as the paymaster?* In short, can they do their job so that we can do ours? Only a fairly confident "yes" merits a proposal.

We conclude with reference to one successful foster care proposal (they obtained the contract) from an agency that had clearly done its homework and knew that it wanted to go forward. Its 40-page text is supplemented with about 300–400 (unnumbered) pages of attachments that, among other things,

- list 14 potential subcontractors, a richly diversified group, with letters of commitment

- include three clear, detailed organizational charts (service delivery, administration, program, and fiscal management)

- include a detailed four-page implementation plan with timelines for each item covering three-and-one-half months

- follow the RFP item by item and provide plans, assurances, and details of assumptions at each point
- describe the preparatory steps already taken: acquiring necessary accreditation, acquiring advanced computer capacity, creating a managed care division, and assembling funds to enable the agency to assume financial risk and cover the transition (detail provided)
- promise all that the contracting agency could hope for and more, claiming that it has much more than the needed capacity and define how it is equipped to do with "incentivized provider reimbursements tied to child and family outcomes"
- describe a pattern of board oversight and understanding of the child welfare reform agenda (as per Chapter 1)
- raise questions about three specified outcomes while expressing confidence in the agency's ability to meet the state's foster care goals
- describe its new subcontract with a for-profit management group to implement a system of "continuous improvement" in the quality of its management
- identify the agency's concerns as to whether the responsible judges are supportive of the plan; the agency will meet with judges in the implementation phase but also will call on the department for necessary "political ground work" in their support
- provide job descriptions and CVs for agency leaders and key line staff
- provide a full cost proposal, per child per program year, with a full listing of assumptions and a narrative explanation (after negotiations, its "best and final" offer cuts these cost proposals modestly)
- respond to all state questions in an extensive question-and-answer section, adding specificity and detail to the proposal and modifying it for the best and final offer. (The agency outlines a staff training program, notes corrections in outcome criteria that take account of their suggestions, and holds firm on several matters of professional principle.).

We have noted in this and other successful proposals that applicants offer everything asked for and then some, demonstrating their adherence to essential philosophical premises and some creativity in "taking ownership" of them. This is a joining in a professional mission, not a mere business transaction. Perhaps this is a transitional phenomenon, but perhaps not. The adding of business mechanisms and principles to sound welfare programs may increase accountability, control costs, and discourage dysfunctional incentives—but they should not move agencies from their humane objectives and missions of service. This does not appear to be unreasonable.

Note

1. David L. Emenhiser et al., *Networks, Mergers and Partnerships in a Managed Care Environment*, (Washington, DC: Child Welfare League of America, 1998).

A Concluding Note

A new era of privatization contracting is under way, continuing public funding but involving transfer of previously publicly delivered services and publicly carried administrative functions to the private sector, both for-profit and nonprofit. Concepts and methods developed by business-oriented managers (many in the health field) are being tested (or adopted without full testing but monitored) for their contributions to more effective and efficient service delivery. They also are being watched or formally monitored by reformers who are committed to a vision of local child welfare reform.

As we have seen, despite a significant amount of promotion, thus far the segment of child welfare actually touched by new organizational initiatives is small, although there are some manifestations of it in perhaps half the states. Many public authorities continue traditional purchase-of-service (POS) contracting and some choose to call their initiatives "managed care." In most instances, the public authorities who have initiated changes have decided to retain the child protection and the managed care organization (MCO) roles. But the business-oriented devices of managed care characterize their relationships with providers and with administrative and information service organizations. Thus far there appear to be only one or two instances of for-profit MCOs with broad contracts, although the field has been opened to them. Most of what are listed as manifestations of managed care is the contracting with a lead agency to create a delivery network, whether a network for one type of service (family preservation, congregate care, adoptions) or a comprehensive network delivering most or many child and family social services for a geographic area. This development is part of a normal and positive evolution in the search for an integrated "seamless" system of services, on the reform agenda for many decades, but it now has financial muscle.

We have in fact found a conceptual continuum between pure POS contracting and pure managed care, but in the real world we found no pure types. Current developments are somewhere in between. Most organizational innovation, whatever the label, involves some degree of access and care management, prospective

payments and risk sharing, contracted performance and outcome criteria, and related monitoring.

Whatever the label, it will not be possible to allay many of the concerns about the reforms, unless the guiding star is a concept of delivery reform that will implement a desired mission. This, of course, is the theme that introduced this guidebook (Chapter 1). Perhaps the mission and efficiency notions—each with considerable validity—can be combined as follows: Child welfare reform requires policy and delivery reform that incorporates business concepts and mechanisms so as to become more effective and affordable in pursuing the child welfare mission.

We have highlighted the respective tasks of the public authorities who launch the process, the agencies that prepare the requests for proposals (RFPs), and those who rate the responses and who negotiate the contracts with the "winners." We also have reviewed the choices to be faced by the potential bidders for a provider or an MCO role. In all of this we have drawn on the as-yet limited experience and concluded that our most useful approach is to be empirical—while encouraging deliberateness and self-awareness. In this spirit, while commenting on experience and introducing various value considerations, we have held that this is not a time or place to fully promote or to dismiss out-of-hand privatization, traditional POS, managed care, or some of the merged models. We have taken a similar stance with regard to for-profit MCOs and the currently favored performance and outcome measures. Nonetheless, we have suggested where the various parties involved need to particularly ponder choices and to move deliberately. All of these issues also pose challenges to researchers and evaluators.

A few direct comments on the issue of contracting with for-profit agencies. Since the welfare reform of August 1996, the door has been open to private, for-profit, contracting for child welfare services. There is already a history with regard to private, for-profit contracting of behavioral health, prison, and detention services. The problems and issues involved are now clear: Whatever their qualification and expertise, private, for-profit businesses have their own raison d'être. Their first loyalty is to their owners–shareholders. Unlike the private nonprofit, the primary loyalty is not to the welfare and development of families and children. (Of course in either instance local circumstances can change or distort motives.)

Thus, a child welfare contractor must consider this reality in choosing a for-profit MCO or Administrative Services Organization (ASO) and in specifying terms and monitoring arrangements in an RFP and contract. On balance, are the motives favorable? As suggested earlier, perhaps a distinction should be made between direct family and child services on the one hand and administrative functions (management advice or management information systems) on the other hand. Of course, this distinction has not been made for health services, but there is still some debate.

Another issue, mentioned but not probed earlier, requires further highlighting: the (possible? alleged? inevitable?) tension between the promotion of community-based services involving a strong local role in service delivery and governance, as described in Chapter 2, and the centralizing tendencies of managed care. In effect, child welfare is currently experiencing three policy "campaigns": advocacy of community–neighborhood anchored service delivery; advocacy of managed care; and advocacy of the federal policy initiatives. Presumably the federal goals are compatible with both managed care and neighborhood-based delivery. But are managed care and neighborhood-centered delivery mutually compatible?

There is not enough documented experience with highly decentralized and locally guided, controlled, and adapted service delivery to offer a definitive answer, but organization theory and management practice offer reason to pause. An MCO with a comprehensive mandate, a lead agency with subcontracts, or a provider with a contract in a managed care regime can assume risks and contract for a prospective payment system only if it has enough control to

- control access
- manage and integrate care
- monitor outcomes closely
- deploy resources strategically
- calculate risks carefully
- benefit from the "law of large numbers," enough volume to expect "averages" to work out.

The current emphasis on neighborhood-based services (see Chapter 2) is justified by a search for diversity, local relevance, cultural competence, and local involvement. If this trend is to be cultivated and its possibilities probed and tested, it cannot be expected to serve well an initiative dependent on standardization and control.

None of this yields a definitive conclusion, but there is reason to see these two tendencies as in conflict. At the very least it would appear reasonable to suggest that we need to learn out of experience and, then, rigorous research what can be achieved by (a) concentrating on the neighborhood and "Family to Family" strategies unencumbered by managed care, (b) by choosing the managed care route, unencumbered by community-based and locally controlled systems, or (c) by exploring whether there are effective blendings of the two. Current decentralization approaches assuming managed care elements tend to visualize a county department as a base, not a city neighborhood or district.

Finally, the issue of scope. If managed care in child welfare is excessively cast in the mold of the medical model, it could continue the current undesirable tendency in some places of failing to assign resources to help families with less-severe problems of individual adaptation, child rearing, dependency, and deprivation, which often then become exacerbated. To help such families is wise and essential, whatever the more urgent pressures of serious neglect, abuse, delinquency, and family breakup. The new contracting must allow space for all of this, recognizing that it involves a departure in delivery model and includes early intervention, educational and socialization services, mutual aid, and much else.

There are champions of managed care tools who see the possibility of including at least secondary preventive activities. This is the case with some Colorado county plans and Iowa proposals. They are not dissuaded by the views of one analyst to the effect that "child welfare is about the life of a child; managed care is about coping with a problem or an episode." To them managed care must cover prevention. The proof is yet to come.

Beyond this is primary prevention or what we would call "social policy," some of it state and some federal. The domains include jobs, income, parental time, and basic services (such as health and child care). The specifics, which go well beyond this guidebook, must be elaborated elsewhere.

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